HEALTH ACTION
Priorities for Monroe County

Maternal/Child Health Report Card
December 2003

Prepared by the Monroe County Department of Public Health and Action for Healthy Children on behalf of **HEALTH *ACTION***

For more information call the Monroe County Department of Public Health Community Health Improvement Unit at 274-6075

Table of Contents

Minimize the Impact of Asthma

Improve Nutrition and Physical Activity

Reduce Exposure to Lead

Reduce Unintentional Injuries

Improve Social and Emotional Well Being

Reduce Child Abuse, Neglect and Violence Against Children

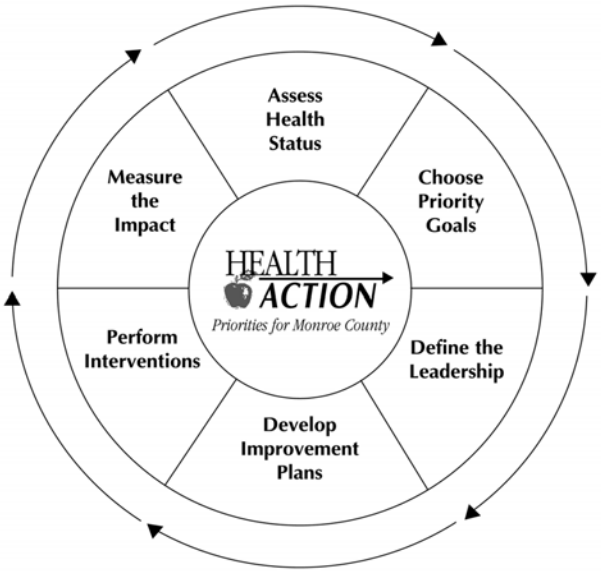
Index

Introduction

HEALTH *ACTION* Overview

In 1992, the report Pathways to a Coordinated System of Health Care and Human Services for Children and Families in Rochester, New York was published. The Pathways report initiated the process of regularly updating the community about the health of children and families in the form of the Maternal/Child Health Report Card. This process has become part of a larger community health improvement effort known as **HEALTH *ACTION***: ***Priorities for Monroe County.*** Report cards have been published and updated in five focus areas: maternal child health, adolescent health, adult health, older adult health and environmental health.

The goal of **HEALTH *ACTION*** is to involve individuals, health care systems, businesses and the public health community in a process to improve the health of Monroe County citizens as depicted below:



The release of the 1997 Maternal/Child Health Report Card was a significant step in building a community agenda to address priority health issues for children and families in Monroe County. The Monroe County Board of Health sought community participation in establishing priorities for action from the seven health goals in the Maternal/Child Health Report Card:

- Improving Birth Outcomes
- Improving Access to Preventive Services
- Minimizing the Impact of Chronic Disease
- Reducing Exposure to Lead in the Environment
- Reducing Violence, Abuse and Maltreatment against Children
- Reducing Unintentional Injuries to Children
- Improve Dental Health of Children

This process involved meeting with several groups of providers, consumers, and representatives of community agencies serving mothers and children. Participants were asked to rank each goal against five criteria including importance, sensitivity to intervention, control, resources required and how much time would be needed to effect change.

The two goals chosen as priorities for action were:

- Improving Birth Outcomes
- Improving Access to Preventive Services including Dental Services

In addition, the Board encouraged key stakeholders to take the following actions related to the issue of reducing violence, abuse and maltreatment of children:

- Initiate a focused discussion of issues
- Collect information on services provided and
- Incorporate preventive strategies into new program development.

HEALTH *ACTION* Partnerships formed to address the two priorities for action and have been working for five years. Progress reports for each of these goals are on pages 4-11.

The release of the 2003 Maternal Child Health Report Card provides a current assessment of the health of mothers and children in Monroe County. This report card reviews the progress made on the priorities for action established in 1998, and presents current data in each of eight goal areas.

- Improve Birth Outcomes and Infant Health
- Improve Access to Preventive Health Services
- Minimize the Impact of Asthma
- Improve Nutrition and Increase Physical Activity
- Reduce Exposure to Lead
- Reduce Unintentional Injuries
- Improve Social and Emotional Well Being
- Reduce Child Abuse, Neglect and Violence Against Children

The Monroe County Board of Health has designated Action for Healthy Children to lead a process of obtaining input from community agencies, providers and consumers about which of the goals in this report card should be areas of focus for the next several years. Action for Healthy Children will make recommendations to the Board of Health which will make the final decision.

Format of this Report

This report is divided into three sections as follows:

- A Progress Report on the Priorities for Action from 1998
- A Background Data section that contains demographic and socioeconomic data related to children and families.
- A Goals section containing eight goals for maternal/child health. For each goal there is a discussion of current data, emerging issues related to the goal, and a summary of community programs addressing the goal.

Definition of Trends:

In this document, a trend is defined as the shift or movement in a series of data points observable over time. If there is no shift or movement over time, by convention, statisticians conclude that there is no trend.

Whether the shift or movement is statistically significant is defined by the chi-square for trend. If the p value of the chi square for trend is < 0.05 then the trend is statistically significant. If the p value for the chi-square for trend is > 0.05 then the shift or movement in the data is not statistically significant. The direction of the trend is determined by whether the data points increase or decrease in value over time.

Progress Report-

HEALTH *ACTION*
Priorities For Action: 1998-2003

Priority for Action : Improving Birth Outcomes:

In 1998, the Perinatal Network of Monroe County (PNMC) and the Hospital Consortium of Greater Rochester initiated the **HEALTH *ACTION*** Partnership to address the goal of improving birth outcomes. The Hospital Consortium was dissolved in 1999. Since then the Perinatal Network has provided the sole leadership for this partnership.

PNMC is one of 15 such networks in New York State. Established in 1996, PNMC brings together local health and human service providers, insurers, community groups, and consumers with a common mission: to improve perinatal services and birth outcomes in Monroe County. As a networking organization, PNMC serves as a neutral forum for individuals and agencies throughout the county to plan and problem-solve around local perinatal needs and issues.

A needs assessment conducted by the PNMC and the Monroe County Department of Public Health documented significant disparities in birth outcomes within Monroe County. Rates of poor birth outcomes are highest among African-Americans and those who reside in the southwest and northeast sections of the city. The assessment also documented that there are an abundance of medical and social services in Monroe County, but there is a lack of coordination among them, and there are barriers to receiving services. Given the fact that both social and medical factors contribute to poor birth outcomes, and often these factors are interrelated, it makes sense to address these issues through coordinated medical and community based interventions.

Community Programs to Improve Birth Outcomes and Infant Health

In 1997, the Perinatal Network was chosen as one of 40 new grantees to be funded for a federal maternal-child health initiative entitled Healthy Start. The overall goal of Healthy Start Rochester is to improve birth outcomes in the southwest and northeast sections of the City of Rochester. Healthy Start Rochester funding provided three levels of coordination:

- Individual participant care coordination (Healthy Start Center)
- Service coordination to promote more effective outreach services
- Community consortium to develop an active consumer and community "voice"

Opened in 1998, the Healthy Start Center (HSC) was designed with community input to be a user-friendly center, providing a comprehensive array of health and human services in a single accessible location, with flexible hours to meet client needs. This "one-stop"

center, located in Southwest Rochester, addresses many of the barriers to accessing comprehensive continuous prenatal care. At the HSC, Unity Health System works to meet the medical care needs of women children and their families, while social needs are address by the following agencies: the Catholic Family Center, Family Resource Centers of Rochester, Monroe County Legal Assistance Corporation, Rochester City School District, American Cancer Society, Cancer Action, Monroe County Cooperative Extension and Urban League of Rochester. Services offered at the HSC include:

- Breastfeeding and Childbirth Education
- Health Education, Cooking and Nutrition Classes
- Parenting Sessions
- GED Preparation Classes
- Legal Assistance
- Smoking Cessation
- Self Esteem and Mental Health Support
- Coping with Stress and Depression
- Support Groups for Teens and For Victims of Sexual Abuse

Data show that the HSC is reaching women who have risks for poor pregnancy outcomes including smoking, drug use, medical risk factors, and poor prenatal outcomes from prior pregnancies.

In addition to the HSC, Healthy Start Rochester has created a partnership with existing outreach programs to improve coordination and collaboration to promote more effective outreach services. Agencies involved in this collaboration include: the Anthony Jordan Health Center, Baby Love, Rochester Early Enhancement Program (REEP), Healthy Moms, and the Community Health Worker Program of the Monroe County Department of Public Health. By partnering with these existing outreach programs HSR has created new strategies to reach women who were traditionally hard to reach and serve. HSR has worked with these programs to develop a common database which allows the programs to continually evaluate and respond to changes in service delivery and outcomes in a timely manner.

HSR has also addressed the need for coordinated and enhanced outreach worker training to build upon existing skills and knowledge base of staff. Funding was provided to these agencies to allow staff to take advantage of a variety of educational forums. As a result of these collaborative efforts, the Rochester Outreach Workers Association (ROWA) was formed in 1999 to offer regular training and networking sessions.

The Community Consortium of HSR, named Community Unity for Healthier Babies (CUHB) has the overall goal of promoting community involvement to improve birth outcomes and perinatal health care in the community. CUHB facilitates a two-way learning process between consumers and service providers. Consumers are able to educate providers on their needs and traditional social and cultural values, while providers have been able to educate consumers on various issues including health and social problems. This mutual education has broken down many of the barriers to women's healthcare in the Healthy Start Area.

The PNMC has received funding to continue Healthy Start Rochester for an additional four years. While Healthy Start has shown signs of success disparities in birth outcomes between the Healthy Start target area and the rest of the county remain high (evaluation

data are available from Healthy Start Rochester[1]). Over the next four years HSR will focus on the following areas:

- Expanding the project area from six to nine zip codes and expanding the age of coverage from 1 to 2 years of age
- Extending the community dialogue to include more providers and consumers
- Enhancing perinatal care to include improved perinatal depression screening and referral services as well as improved comprehensive smoking cessation programs for pregnant women and those living in their households
- Continuing to work with outreach partners to make uniform data collection routine and to use data to improve delivery of services
- Extending the perinatal outreach network to include activities of community outreach workers and community-based organizations
- Promoting awareness of and advocacy for improved perinatal health care among consumers and community residents

In addition to Healthy Start Rochester, the Perinatal Network is focusing on addressing the following areas: perinatal HIV, substance use, perinatal/postpartum depression, and smoking cessation for pregnant women and household members. The Perinatal Network also tracks perinatal data and trends, and offers a perinatal web site, resource directories for general and specialized local services, and extensive professional and public education.

Additional Community Programs to Improve Birth Outcomes

Finger Lakes Regional Perinatal Forum

For over a decade, NYSDOH has funded the University of Rochester Medical Center as a Regional Perinatal Center. Traditionally, these centers have provided leadership in the development of regional systems to assure that high-risk deliveries occur in appropriate clinical settings and that obstetrical providers are aware of the specialized perinatal services in their region. In 1996, the Regional Perinatal Center at the University of Rochester assumed responsibility for the regional perinatal data system.

NYSDOH also funds regional perinatal networks to assure the quality and availability of community based perinatal services including support services. Beginning with the 2002-03 budget year, NYSDOH required that all Regional Perinatal Centers and Perinatal Networks establish a regional forum to work collaboratively to improve perinatal outcomes.

The forums will review and track regional perinatal data, identify regional perinatal needs, identify groups and resources available to meet them, and develop and implement an action plan to successfully address the needs. The overall intent is to get clinical and community providers to work together around common concerns and to improve perinatal outcomes.

Participants in the Finger Lakes Regional Perinatal Forum include former perinatal database advisory groups, health care providers, county health departments, community

[1] 546-4930

groups, consumers, 3rd party payers, and others interested in perinatal care and outcomes. Monroe County is part of the nine-county Finger Lakes[2] Regional Forum.

The initial two areas of focus that have been chosen by the Finger Lakes Forum are to promote breastfeeding, and to encourage smoking cessation for pregnant women and parents. In both areas, local data indicates a need. Barriers and resources have been identified; and plans are in progress for choosing and/or implementing specific actions.

Breastfeeding Promotion and Support

All WIC programs serving Monroe County residents promote breastfeeding as the optimal choice for infant feeding. Interventions vary by program. Some of the interventions include prenatal breastfeeding classes, a free breast pump rental program for participants, follow up supportive phone calls to breastfeeding mothers, breastfeeding help-lines, and educational materials.

All of the hospitals in Monroe County have breastfeeding help-lines and have one or more International Board Certified Lactation Consultants on staff. Rochester General Hospital has been certified as a Baby Friendly Hospital by implementing the "10 Steps to Successful Breastfeeding" developed by the World Health Organization. All of the other hospitals in the community are also using these guidelines in order to improve breastfeeding support given to patients.

Nutrition Education for Pregnant Women

Cornell Cooperative Extension (CCE) provides nutrition education to families with limited resources. As part of a statewide grant in 2002, CCE will increase recruitment efforts with pregnant women and new mothers. They will provide educational services related to healthy eating and feeding options for their newborn. The WIC programs serving Monroe County provide both group and individual nutrition education to pregnant and parenting clients that focuses on healthy eating during pregnancy and infant nutrition. Nutrition counseling through health centers and hospitals is also available for pregnant women with special health conditions during pregnancy, such gestational diabetes.

Summary of Measures of Improving Birth Outcomes

Below is a summary of the significant changes in indicators of birth outcomes that have occurred during the past several years. Details of these data can be found on pages 24-36.

Data has shown mixed results in working towards improving birth outcomes in Monroe County.

- Between 1990 and 1999, the infant mortality rate improved overall. The rates among city residents and African Americans showed the greatest improvements. In 2000, the rates county-wide increased, however provisional data show that the rates improved again in 2001 and 2002.

- The death rate from SIDS improved between 1992 and 2000.

[2] 9 counties (Monroe, Livingston, Wayne, Ontario, Seneca, Yates, Steuben, Schuyler, Chemung)

- The low birth weight rate has worsened since 1990, mainly because of an increase in twin and triplet births.

- Significant disparities in measures of birth outcomes remain between city and suburban residents and between African Americans and Whites. These measures include the infant mortality rate, low birth weight rate, prematurity rate, and the rate of early entry into prenatal care.

- The rate of newborns discharged from hospitals with a drug-related diagnosis has improved since 1991.

- Rates of HIV testing during pregnancy are very good at about 95%. Since 1998, the mother to child transmission of HIV has been 0%, while the number women who are seropositive giving birth has remained constant.

- Breastfeeding rates have improved, especially among WIC participants.

Priority for Action: Improving Access to Preventive Services

In 1996 Dr. Elizabeth McAnarney, chairperson of the Department of Pediatrics at the University of Rochester School of Medicine, convened Action for Healthy Children[3] (AHC), which has guided the community efforts to address this priority for action. In addition, Buddhi Shrestha, Ph.D., D.D.S. has provided leadership in convening the Rochester Oral Health Coalition. This group works closely with Action for Healthy Children to improve access to preventive dental services in the community.

Action for Healthy Children has divided its work into two main areas:

- the development of data systems for monitoring access to preventive services
- planning interventions to improve access to preventive services

Monitoring Access to Preventive Services

In 1999, AHC developed a set of measures to monitor access to preventive services. The Immunization and Primary Care Survey a random sample survey of 2 year old and 11-14 year old children receiving care in primary care practices in Monroe County was conducted in both 1999 and 2002. This survey monitors rates of insurance coverage and immunization rates, as well as other health indicators.

In August 1999, the Primary Mental Health Project (PMHP) completed and released the first Parent Appraisal of Child's Experiences (PACE) Report. The PACE survey developed by the Monroe County Department of Public Health, the Rochester City School District and the PMHP (now called the Children's Institute) is administered annually as part of the Rochester City School registration process. Based on information collected from parents and guardians, this report provides a description of the children who enter kindergarten each year. The PACE includes questions pertaining to health including insurance coverage, and access to medical dental preventive services as well as questions related to school and social indicators. Since this survey is administered

[3] Current members of Action for Healthy Children can be found on page 93.

annually it will allow the community to monitor over time, indicators of access to preventive services among children entering Rochester City Schools.

Other programs for monitoring access to preventive health services have been in place for several years. The Monroe County Department of Public Department monitors cases of vaccine preventable diseases and lead poisoning. The Eastman Dental Center monitors dental health status in Monroe County as part of surveillance funded by Monroe County.

Community Interventions to Improve Access to Preventive Services

Facilitated Enrollment Program

In 1997, the New York State Health Department began offering grants to assist local communities improve enrollment for Child Health Plus A (formerly Medicaid), Child Health Plus B and WIC. Facilitated Enrollment introduced a single application form for the three programs, simplified the application process and contracted for community enrollers to assist families with the application process. The Monroe County Health Department was the original recipient of the grant. In 2003, program sponsorship was transferred to Coordinated Care Services Inc.

In the early years of facilitated enrollment, NYSDOH heavily promoted the program with television, radio and billboard advertising. In the last two years, NYSDOH has expanded the eligibility levels for the health insurance programs and simplified the application process. For example, some of the difficult documentation requirements have been reduced and the need for a face-to-face interview for re-certification for Child Health Plus A (formerly called Medicaid) has been eliminated. NYSDOH has also implemented procedures that enable easier transfer between Child Health Plus A and B. Locally, our facilitated enrollment program has expanded locations and increased the efficiency and productivity of the enrollers.[4]

Outreach Program for Childhood Immunizations

The Child Health Unit at the Department of Pediatrics sponsors the Outreach Program for Childhood Immunizations (the "Outreach Program") at the University of Rochester. Originally, funding came for a randomized controlled trial of outreach to promote improved immunization rates in inner city children from 1993-1995.

Because the trial proved effective, the intervention has been maintained with various other funding sources since 1995 and was expanded to its current level in 1997. Currently funding is through a truly community-wide partnership, involving the health systems (Via Health, Strong Health, Unity Health), the major insurers (Excellus and Preferred Care), and the major provider organizations (the Monroe Plan and RIPA).

The Outreach Program is based within the largest primary care practices serving children who reside in the city of Rochester. The program now serves approximately 2/3 of the children in the City of Rochester. Outreach workers make home visits, remind and recall families of needed appointments, and coordinate services as needed to help families overcome barriers to care

[4] For more information contact Amy Van Orden at aVanOrden@ccsi.org

The program has had a substantial impact on reducing disparities immunization rates between city and suburban children. The childhood immunization rates for children residing in the City of Rochester are about 10% higher than rates across New York State[5].

The Finger Lakes Area Immunization Registry

The Finger Lakes Area Immunization Registry was launched in 2001. The registry is a computerized database of childhood immunizations. It links physician practices in Monroe and ten surrounding counties in a computerized immunization tracking system. The computerized system can help keep children up-to-date on their immunizations by providing medical providers easy access to complete immunization records of their patients, by generating lists of under-immunized children, and by providing immunization reminders for patients.

Rochester Oral Health Coalition

The Rochester Oral Health Coalition (ROHC) is made up of medical care providers, insurers and human service providers interested in improving access to dental health services in Rochester and Monroe County. The Rochester Primary Care Network acts as sponsoring agency. The ROHC has taken an active role in improving reimbursement rates for local dental health providers in the past few years. During that time period, Excellus Blue Cross of the Rochester Region has substantially increased reimbursement for children in the Child Health Plus B Program. Similarly, NYSDOH has substantially raised reimbursement rates in the Medicaid Program. In addition, ROHC played a key role in the recent designation of all of Rochester (except southeast quadrant) as a federal Dental Health Professional Shortage Area.

It is a great tribute to ROHC and its long-time leader Buddhi Shrestha that NYSDOH has created a statewide oral health coalition fashioned after ROHC. Fittingly, Dr. Shrestha has been asked to head up the statewide coalition. The NYS Oral Health Coalition (NYSOHC) has received grant funding to establish technical assistance centers to help communities or organizations in New York State interested in developing innovative oral health programs to improve access to dental care with emphasis on care for under-served vulnerable populations. Rochester Primary Care Network will be the home for this new technical assistance center.[6]

Studies for Reducing or Eliminating Oral Health Disparities in Hispanic Children

In 2002 the University of Rochester Eastman Department of Dentistry and Eastman Dental Center was awarded a grant from the National Institutes of Health/National Institute of Dental and Craniofacial Research to develop sustainable interventions that would reduce or eliminate oral health disparities in Hispanic children. The first step is to determine the oral health status of Hispanic children as contrasted with Caucasian, African-American and other ethnic minority children. The second step will be to identify barriers to access to existing oral health programs and effective utilization of these programs. Armed with these data, the project staff will develop sustainable interventions tailored not only to the reduction or elimination of oral health disparities among Hispanics, but also to other ethnic and socially disadvantaged child populations as well. Ideally, the

[5] For more information contact Mardy Sandler at Mardy_Sandler@URMC.rochester.edu

[6] For more information about the ROHC, contact bshrestha@rpcn.org. For more information about the NYSOHC, contact Donna Altschul at dla03@health.state.ny.us

interventions will be generalizable across the broad spectrum of children with limited access to oral health care and will be implemented in cooperation with community stakeholders.[7]

Summary of Measures of Access to Preventive Services

Below is a summary of the significant changes in indicators of access to preventive services that have occurred during the past several years. Details of these data can be found on pages 38-48.

- Between 1999 and 2002, there was an improvement in the uninsured rate among two-year old children in Monroe County. The rate (3.5%) is better than the US rate in 2001 (10.4% among 5 year old children), but is not at the 2010 Goal (0%). It should be noted that these data are more than a year old. Analysis of trends since this survey was conducted, indicate that the rate has once again increased due to the poor economic climate.

- Between 1995 and 2001, there was an improvement in the rate of hospitalizations due to ambulatory care sensitive diagnoses among children ages birth to 9 years old. In addition, there was a reduction in the disparities between African Americans and Whites in this age group.

- Between 1997 and 2001, the rate of one and two-year old children who were screened for lead poisoning declined. Since 2002, however, the rate appears to have increased.

- Between 1999 and 2002, the immunization rates of two-year old children in Monroe County worsened. Rates in Monroe County and the Inner City of Rochester are still better than rates in the U.S. and NYS.

[7] For more information contact Dr. Ronald Billings at Ronald_Billings@URMC.rochester.edu.

Background Data

Population 1990-2000

According to the 2000 Census, there were 101,638 children under age 10 residing in Monroe County. This number declined by 3% between 1990 and 2000. The decline was mainly due to the decrease in the number of births that occurred throughout the 1990s.

Number of Children Under Age 10 , Monroe County ,1990 and 2000

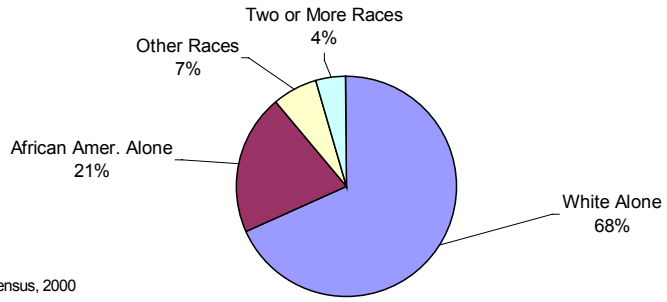
	1990	2000	% change 1990-2000
Monroe County			
0-4	54,587	46,977	-13.94
5-9	50,047	54,661	9.22
<10	104,634	101,638	-2.86
Rochester			
0-4	21,808	17,227	-21.01
5-9	16,722	18,733	12.03
<10	38,530	35,960	-6.67
Suburbs			
0-4	32,779	29,750	-9.24
5-9	33,325	35,928	7.81
<10	66,104	65,678	-0.64

Source: Census 1990 and 2000

Population By Race and Ethnicity

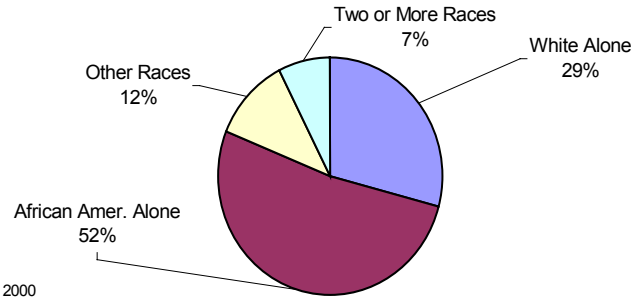
In order to better reflect the country's diversity, the 2000 Census allowed respondents to select more than one race to indicate their racial identity. In Monroe County, the majority of children under age 10 are White (single race). In the City of Rochester, the majority of children are African American (single race).

Children Under Age 10,
By Race, Monroe County, 2000



Source: Census, 2000

Children Under Age 10, By Race,
City of Rochester, 2000



Source: Census, 2000

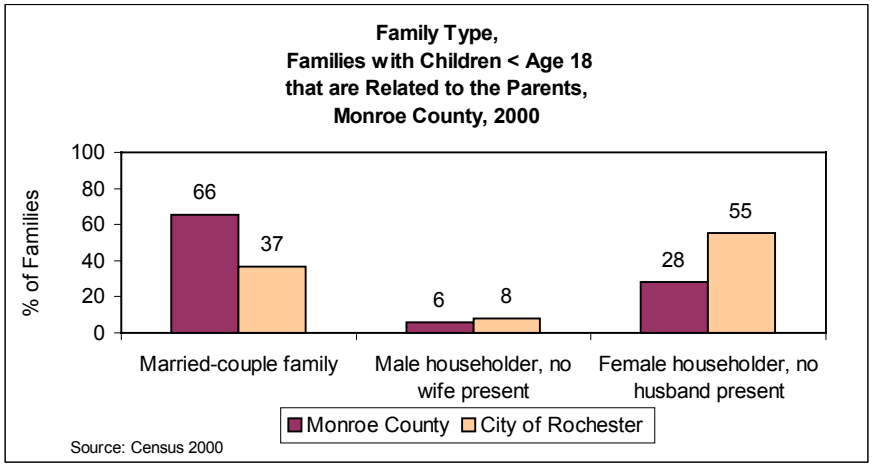
Because in 2000, the Census Bureau changed how respondents identified their race, data from previous years could not be compared.

The U.S. Census Bureau considers race and ethnicity to be two separate identifiers. Hispanic ethnicity is defined as an individual of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The number of Hispanic children under age 10 in Monroe County increased between 1990 and 2000, from 6,394 to 9,278. Nine percent of children under age 10 in Monroe County and 19% in the City of Rochester are of Hispanic Origin.

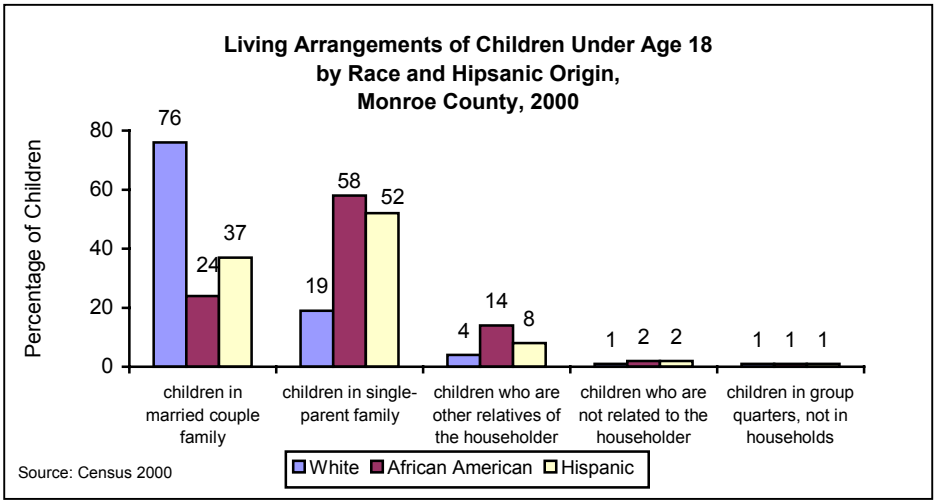
Family Structure

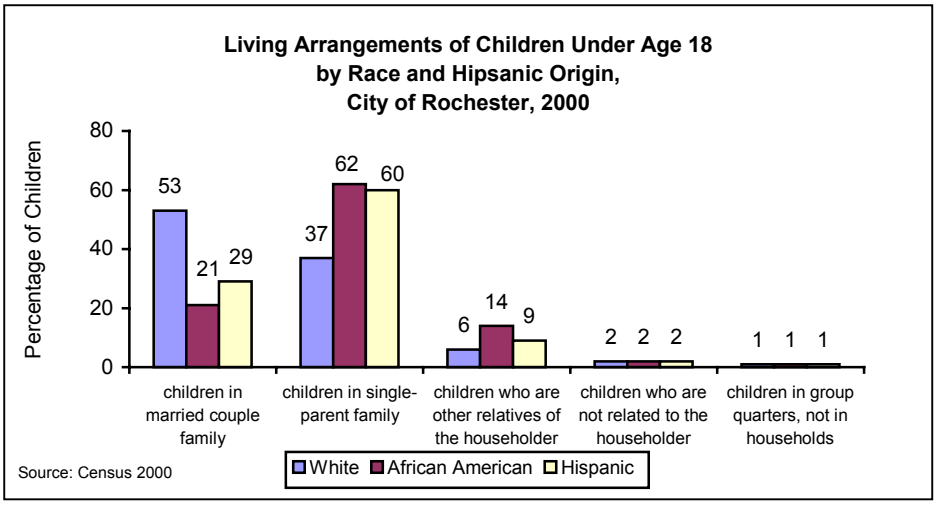
Children who live in married-couple families tend to have more resources available to them than children who live in single-parent families.

The majority of families with children in Monroe County are married couple families. Within the City of Rochester however, most families with children are single parent families. These single parent families may include households with two unmarried partners.



The majority of African American and Hispanic children live in single parent families.

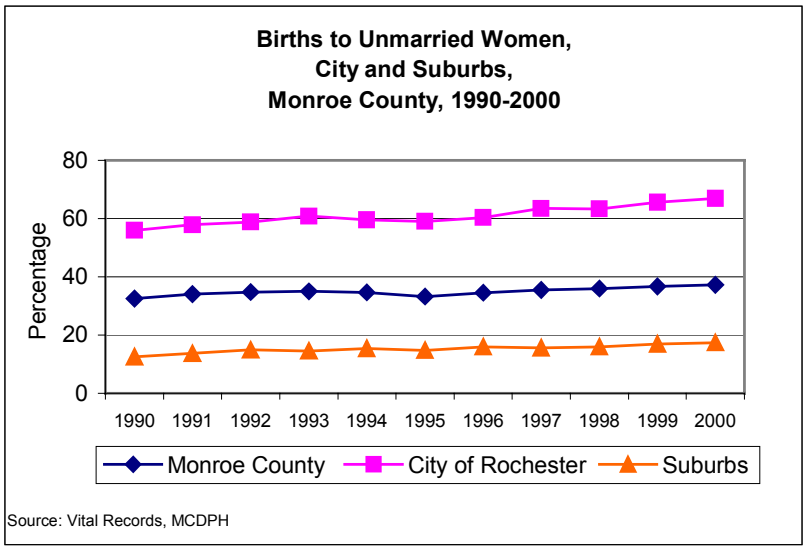


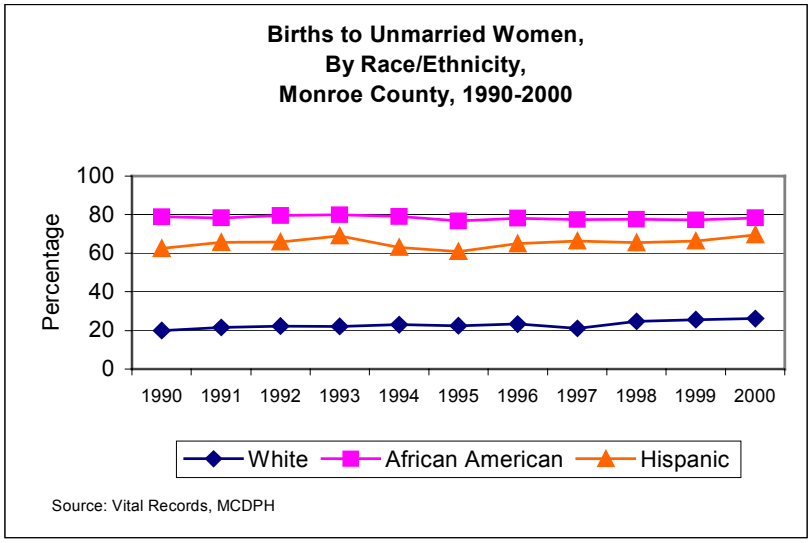


Births to Unmarried Women

Unmarried mothers tend to have lower incomes and educational levels than women who are married.[8]

In Monroe County during 2000, 3,500 babies were born to unmarried mothers. The percentage of babies born to unmarried women in Monroe County (37.2%) is higher than Upstate (28.9%) and is similar to the rate in New York State. Between 1990 and 2000, the rates of births to unmarried women increased in Monroe County, the city of Rochester and the suburbs. The percentage in the city is nearly four times higher than in the suburbs. The rates among African Americans (78.3%) remained stable during this time period and are three times higher than the rates among Whites (26%).



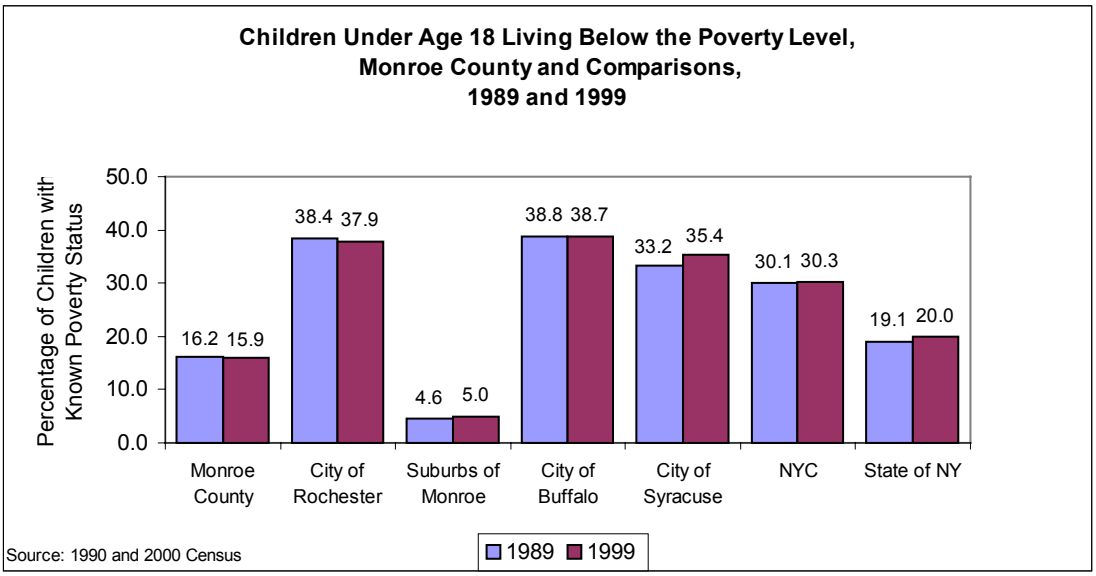


[8] Terry-Humen, E., Manlove, J., & Moore, K. A. (2001). Births outside of marriage: Perceptions vs. reality. In Child Trends, Research Brief. Washington, DC: Child Trends. http://www.childtrends.org/PDF/rb_032601.pdf

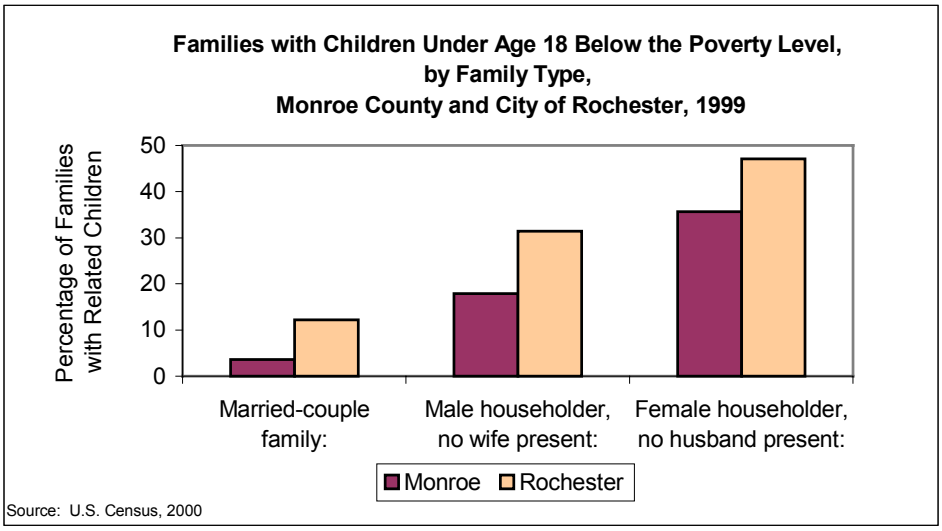
Children Living In Poverty

Living in poverty during childhood has both immediate and lasting effects. Children living in poverty are more likely to have poorer outcomes in the areas of health, education and economic security.[9]

Sixteen percent of children under age 18 in Monroe County live in poverty. The child poverty rate is nearly nine times higher in the City of Rochester compared to the suburbs. Since 1990, the poverty rates in Monroe County, the City of Rochester and suburbs have remained stable. The rate in Monroe County is lower than the rate in New York State. The child poverty rate in the City of Rochester is slightly lower than the rate in Buffalo, but higher than the rate in Syracuse and New York City.

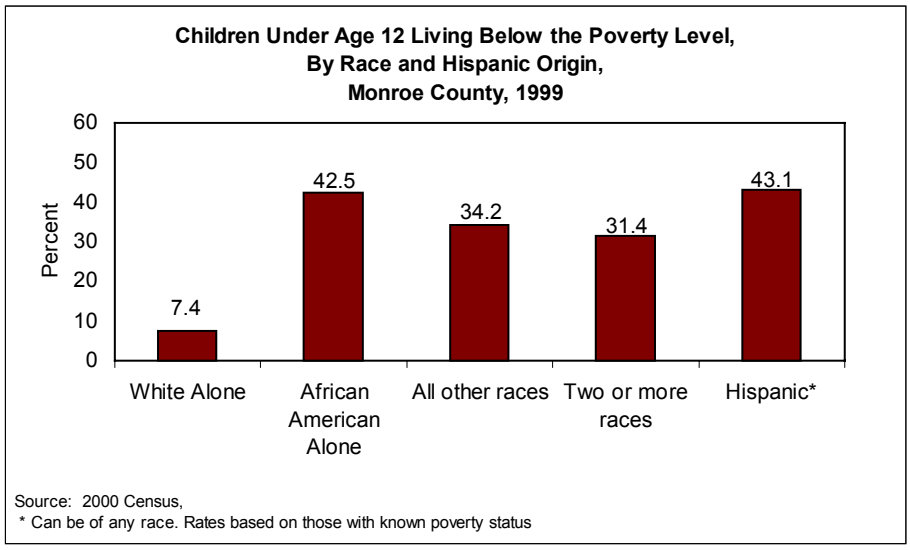


Nearly half of the female-headed single parent families in the City of Rochester live in poverty.

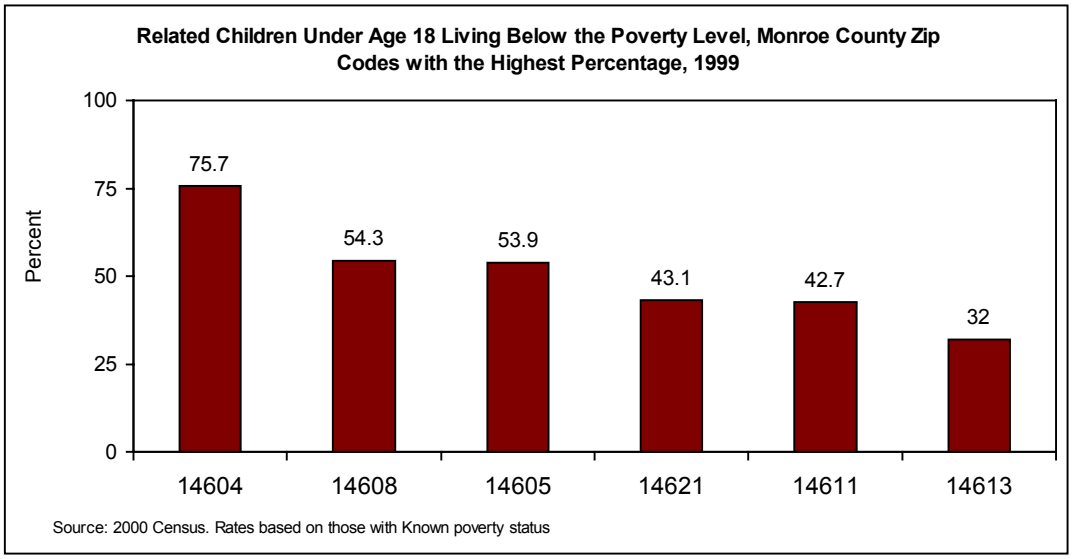


[9] Duncan, G. and Brooks-Gun, J. "Consequences of Growing Up Poor." New York, NY Russell Sage Press.

The poverty rate is significantly higher among minority children compared to White children.



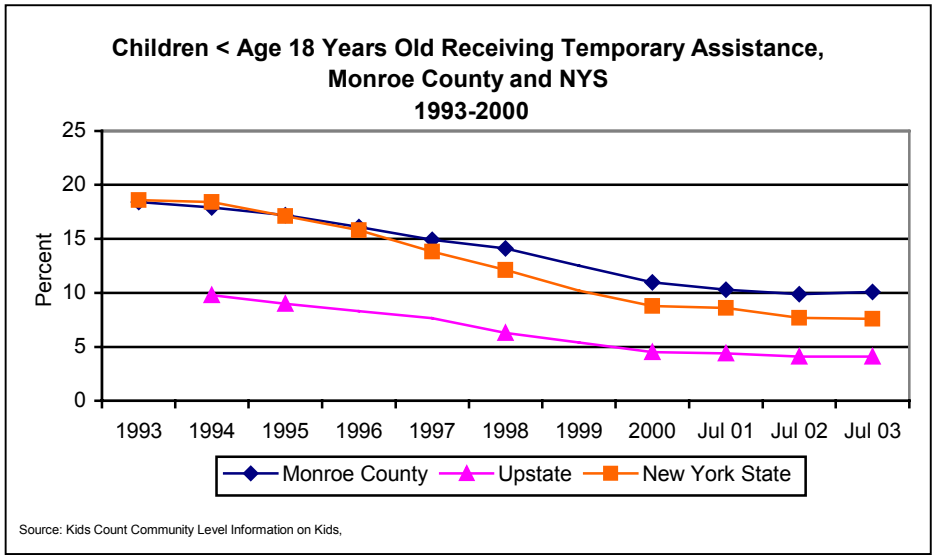
Child poverty rates are highest in certain City of Rochester zip codes.



Children Receiving Temporary Assistance

Despite the fact that child poverty rates have remained stable, the number and rate of children receiving temporary assistance in Monroe County declined between 1993 and 2000. The decline is due in part to the Federal Welfare Reform Act of 1996. Implementation of the act occurred in 1997 and 1998. The reduction in the number of children receiving temporary assistance preceding the implementation of Welfare Reform, was most likely due to a strong economy at the time.

Since 2000, the percentage of children receiving temporary assistance has remained stable at about 9-10%. The percentage is higher than Upstate and New York State.



Source: Kids Count Community Level Information on Kids,

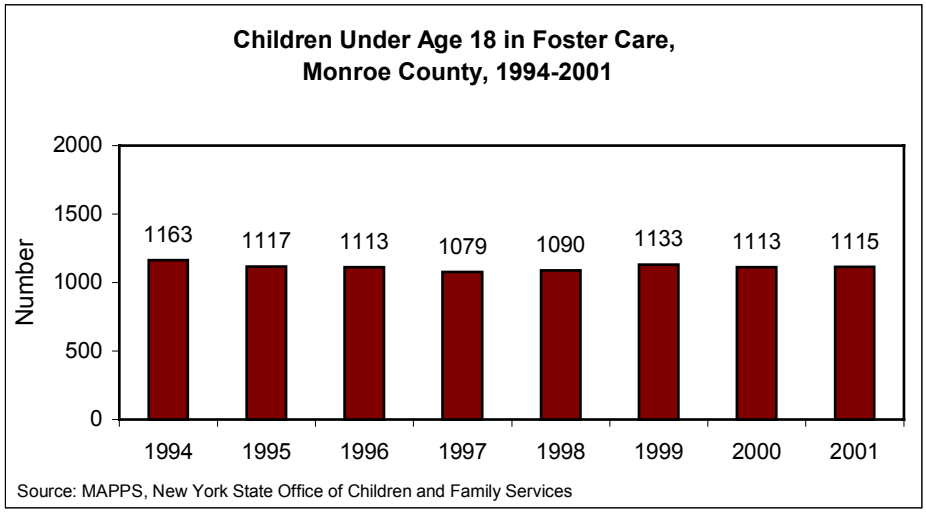
Mobility

According to parents of children entering Rochester schools during the 2001-2002 school year, 33% of children had moved 1-2 times within the past 6 months. An additional 4% of children had moved 3 or more times. Fifty-one percent had moved to another home once or twice in their lifetime, and an additional 20% had moved 3 or more times. (Community Report of Children Entering School in 2001-2002, Children's Institute).

Children in Foster Care

Children are placed in foster care when they are in imminent danger, or their parent is incapable of taking care of them.

At the end of the year in 2001, there were 1,115 Monroe County children under 18 years old in foster care. The number in foster care has remained relatively stable since 1994 as shown in the chart below.



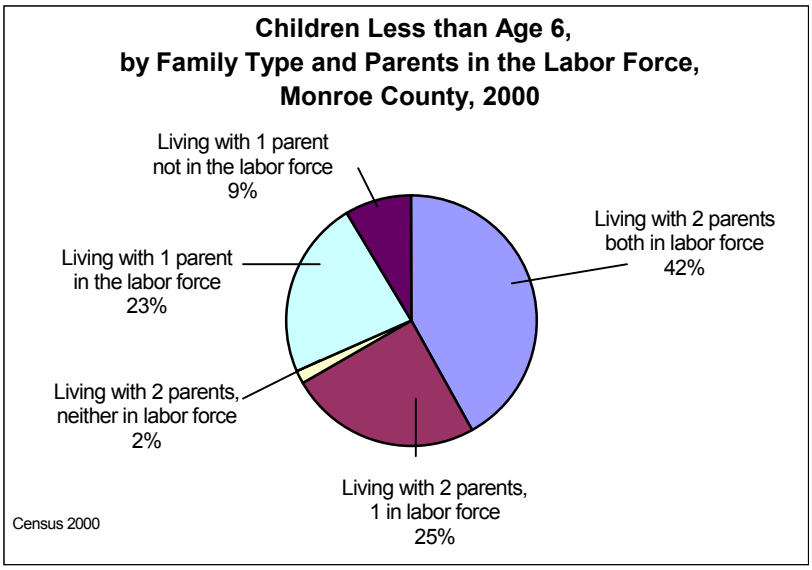
The rate of children in foster care in Monroe County has been historically higher than the rates in other similar NYS counties. In 2001, the rate in Monroe County was 5.9/1000 compared to a rate of 3.7/1000 in comparison counties[10].

[10] Erie, Onondaga, Suffolk, Nassau, Westchester, Monroe

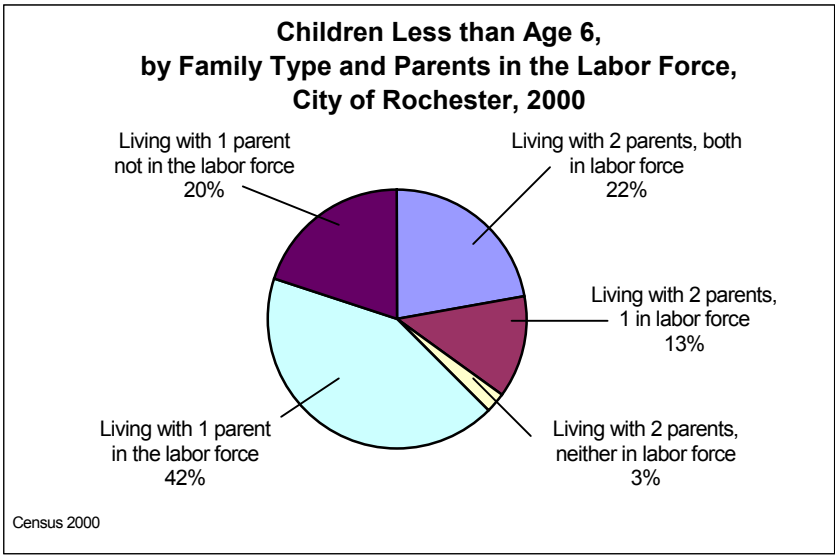
Children and Working Parents

Secure parental employment is essential to a family's economic security. Because many families receive health insurance through their employer, a secure job is a major factor in whether or not a child has access to health care. Parental unemployment often causes major stress within families. Parents who are employed often need child care.

In Monroe County, 11% of children under age 6 are in families in which no parent is in the labor force.



In the City of Rochester, 23% of children under age 6 live in a family in which there is not a parent in the labor force.



Child Care

Increasing numbers of children are spending time in child care. Researchers continue to assess how this affects children's well being.

The table below shows that most children in the City of Rochester stay home during their first year of life. By age 4, however, most children attend child care centers.

Child Care Arrangements, by Parental Report, Children Entering School in Rochester, 2000-2001 and 2001-2002

Age	Home Full Time	Attended Child Care Center	Was in a Caregiver's Home
0-12 Months	73%	21%	18%
13-24 Months	64%	25%	21%
2 Years Old	57%	31%	23%
3 Years Old	43%	51%	20%
4 Years Old	33%	68%	20%

Source: Community Report of Children Entering School in 2001-2002, Children's Institute.

The Center for Governmental Research (CGR) estimates that over 35,000 children (64%) *under age 6* in Monroe County are in need of child care because they live with two working parents or live with a single parent who is working (based on 2000 Census). Monroe County has 19,236 child care slots regulated by NYS Office of Children and Families (including child care centers and licensed family day care homes.) Children not enrolled in these slots are either cared for by parents who arrange their schedule so that they can stay home with their children while the other parent is at work, or in informal child care arrangements, including family members and friends.[11]

Daycare subsidies are available for families with incomes at or below 140% of the poverty level. CGR estimates that there are about 7,200 children *under age 6* who qualify for child care subsidies. In February of 2003, about 5,700 children *under age 6* were enrolled in subsidized child care. Based on these figures, there are an estimated 1,500 children *under age 6* eligible for subsidized child care who are not receiving it.

According to figures from the Monroe County Department of Human and Health Services, in October of 2003 there were 10,332 children *aged 12 and under* receiving subsidized child-care. This number decreased by 22% since January of 2002. Several factors have contributed to the decline. Within the past year, the department has changed the eligibility process and improved the identification of fraud and safety problems. The tightening of the income eligibility requirements from 200% of the poverty level to 140% is another major factor contributing to the decline. While this change affected new enrollments, about 1000 children were retained in the program even though their family's income was between 140-200% of the poverty level.

[11] "Parental Workforce Participation and Child Care for Children Under Age 6 in Monroe County." CGR, April 2003. http://www.cgr.org/areas_of_impact/health/#1055860252.36

Goals to Improve Maternal/Child Health

Improve Birth Outcomes and Infant Health

The Importance of Improving Birth Outcomes and Infant Health

Improving infant health is an important goal because it can impact the health and well being of future generations. Measures of birth outcomes and infant health include infant mortality, low birth weight and prematurity. Babies born at a low birth weight and/or born prematurely are at increased risk of dying within the first year of life and are at increased risk of developing both short-term and long-term health and educational problems. These problems include respiratory conditions, learning disabilities and attention disorders.[12]

Factors that Impact Birth Outcomes and Infant Health

Four major factors that have an impact on birth outcomes and infant health include:

1. Economic conditions
2. Maternal medical risks
3. Maternal behavioral risks
4. Positive maternal behaviors

Women with lower economic status are at higher risk of having poor birth outcomes. Economic status can impact a pregnant woman's stress level, nutritional intake and access to medical care. Women enrolled in Medicaid or those who are uninsured have higher rates of low birth weight and premature births, and are more likely to receive late or no prenatal care. Accessing prenatal care early in pregnancy has many benefits. Early prenatal care can result in the early identification and treatment for problems that may affect the baby's health. Education and counseling for tobacco, alcohol and substance abuse as part of prenatal care, may result in women ceasing to engage in those detrimental behaviors.

Maternal medical risks that impact infant health include a mother's HIV status, the presence of sexually transmitted diseases, gestational diabetes and high blood pressure. Depression among mothers also impacts the health and development of infants.

Maternal behaviors such as smoking, drug and alcohol use all have a major impact on birth outcomes and on the health status of infants. Infants born to women who smoke, and/or use drugs or alcohol are at increased risk of being born at a low birth weight and/or prematurely, and are also at risk for various developmental problems.

Positive maternal behaviors can have a beneficial impact on birth outcomes and infant health. Good nutrition during pregnancy and avoidance of tobacco, alcohol and drugs can help improve birth outcomes. The American Academy of Pediatrics recommends breastfeeding as the preferred choice of infant feeding because it promotes the best possible health as well as the best developmental and psychosocial outcomes for infants.[13] Exposing infants to a nurturing, loving environment with their needs being met can also have a positive impact on their health and development.

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[12] Ventura SJ, Martin JA, Curtin SC, Mathews TJ. Report of final natality statistics, 1996. Hyattsville, Maryland: US Department for Health and Human Services, CDC, National Center for Health Statistics. Monthly vital statistics reports (vol 46, no. 11).

[13] American Academy of Pediatrics Policy Statement: Breastfeeding and the Use of Human Milk http://www.aap.org/policy/re9729.html , cited September 15, 2003.

Measures of Birth Outcomes and Infant Health

Infant Mortality

About the data: The infant mortality rate is calculated by dividing the number of infant deaths in a given year, by the number of live births in that year. Because infant deaths are a relatively rare occurrence, three-year infant mortality rates are calculated here to improve the meaningfulness of the data. The sources of the data are Vital Records of the Monroe County Department of Public Health for 1990-2000 and provisional data from the Finger Lakes Regional Perinatal Data System for 2001 and 2002.

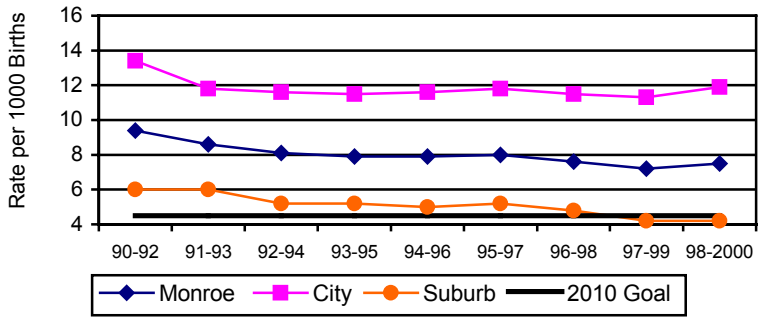
In Monroe County:

In 2000, 87 infants died prior to their first birthday. The three-year infant mortality rate in Monroe County (7.5/1000 births) is higher than Upstate and New York State rates, and is higher than the 2010 Goal.

Overall between 1990 and 1999, the infant mortality rate declined. In 2000, the rate increased. However, provisional data from the Finger Lakes Regional Perinatal Data System shows that the rates declined again in 2001 and 2002.

There are significant disparities in infant mortality rates in Monroe County. The rate in the city is 3 times higher compared to the rate in the suburbs.

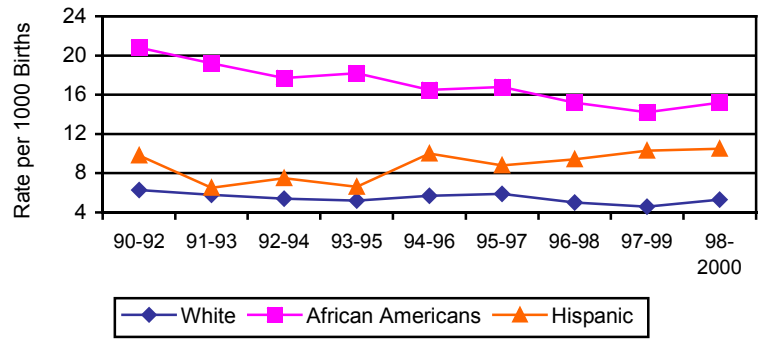
Infant Mortality Rates, 3 Year Moving Averages, City of Rochester, Suburbs and Monroe County Total, 1990-2000 Compared to the Year 2010 Goal.



Source: Vital Records, MCDPH

Compared to Whites, the rate among African Americans is nearly three times higher and the rate among Hispanics is two times higher.

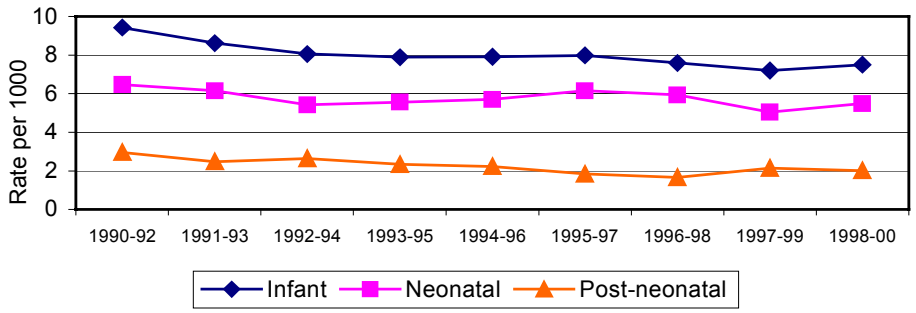
Infant Mortality Rates, 3 Year Moving Averages, by Race and Ethnicity, Monroe County, 1988-1999



Source: Vital Records, MCDPH, FLHSA(Hispanic), 1987-1996

Nearly 75% of infant deaths occur within the first 28 days of life (neonatal mortality). The remaining occur after 28 days and before the child's first birth day (post-neonatal mortality). Although the neonatal mortality rate fluctuated during the 1990s, it remained relatively unchanged. The post-neonatal mortality rate declined.

Infant, Neonatal, and Post-neonatal Mortality, 3 Year Average Rates, Monroe County, 1990-2000



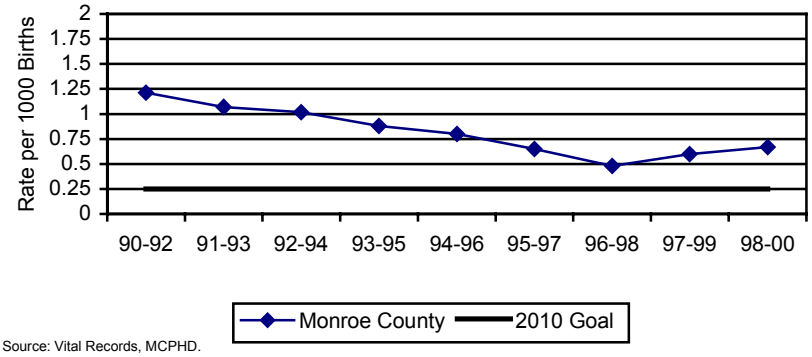
Source: Vital Records, MCPHD

During the past few decades, there have been technological improvements in the care of high-risk newborns that should have resulted in a decline in the neonatal mortality rate. However the significant reductions in the neonatal mortality rate seen in the 1970's and 1980's was not apparent in the 1990's. It is thought that the increase in the low birth weight rate that occurred during this period most likely counter-balanced the effects of the improved technology. Disorders of low birth weight and prematurity are the leading causes of neonatal deaths.

The decline in the post-neonatal death rate is most likely due to the decline in the rate of Sudden Infant Death Syndrome (SIDS). In 1992, the American Academy of Pediatrics implemented the "Back to Sleep" program which educates parents about putting their babies to sleep on their backs. It is thought that this campaign has contributed to the decline in SIDS rates nationally.

In 2000, 6 infants died of SIDS. As shown in the graphic below, the SIDS death rate in Monroe County declined significantly since 1992. Despite the decline however, the death rate remains above the 2010 Goal.

SIDS Death Rate, 3 Year Moving Averages, Monroe County, 1990-2000 and the 2010 Goal



Source: Vital Records, MCPHD.

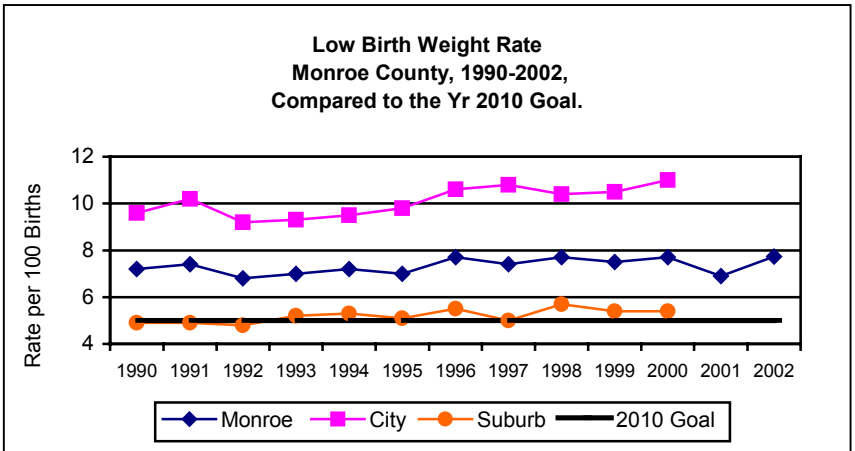
Low Birth Weight

About the data: The low birth weight (LBW) rate is calculated by dividing the number of babies born weighing less than 2500 grams (LBW) by the number of live births with known birth weights. The sources of these data are Vital Records of the Monroe County Department of Public Health for 1990-2000 and provisional data from the Finger Lakes Regional Perinatal Data System for 2001 and 2002.

In Monroe County:

727 infants with a low birth weight were born during 2000. The low birth weight rate in Monroe County (7.7/100 live births) is comparable to rates in Upstate and New York State, but has not met the 2010 Goal.

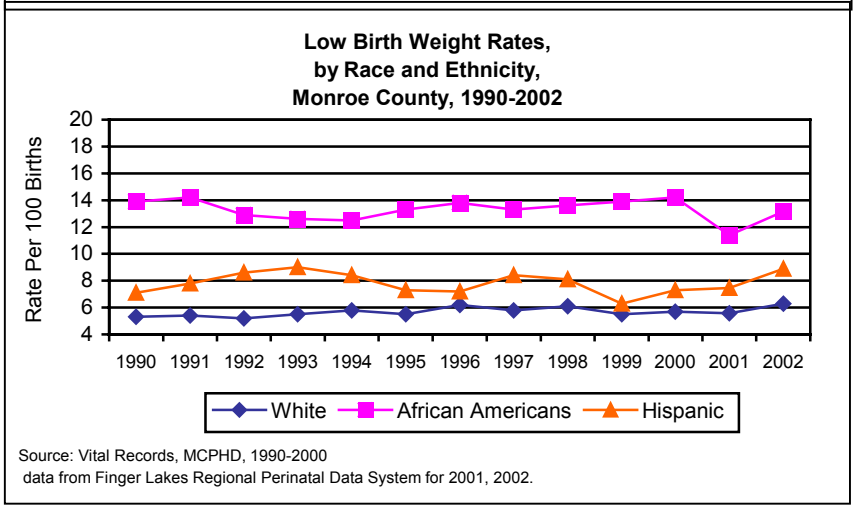
Since 1990, the LBW rate has increased slightly throughout Monroe County. This trend has also been seen nationally and is mainly due to the increase in the number of multiple births. In Monroe County, the percentage of low birth weight babies from multiple births increased from 11% in 1990 to 27% in 2000. This increase occurred both in the city and suburbs.



Source: Vital Records, MCPHD, 1990-2000
data from Finger Lakes Regional Perinatal Data System for 2001, 2002.

There are significant disparities in LBW rates. The rate in the city is two times higher compared to the suburbs.

Among African Americans, the rate is two times higher than the rate among Whites. Rates among Hispanics are one and one half times higher compared to Whites.



Source: Vital Records, MCPHD, 1990-2000
data from Finger Lakes Regional Perinatal Data System for 2001, 2002.

The disparities in low birth weight can be attributed partly to economic risks. The low birth weight rate among Medicaid recipients and among those without health insurance is nearly two times higher than the rate among those with private or commercial health insurance.

Very Low Birth Weight

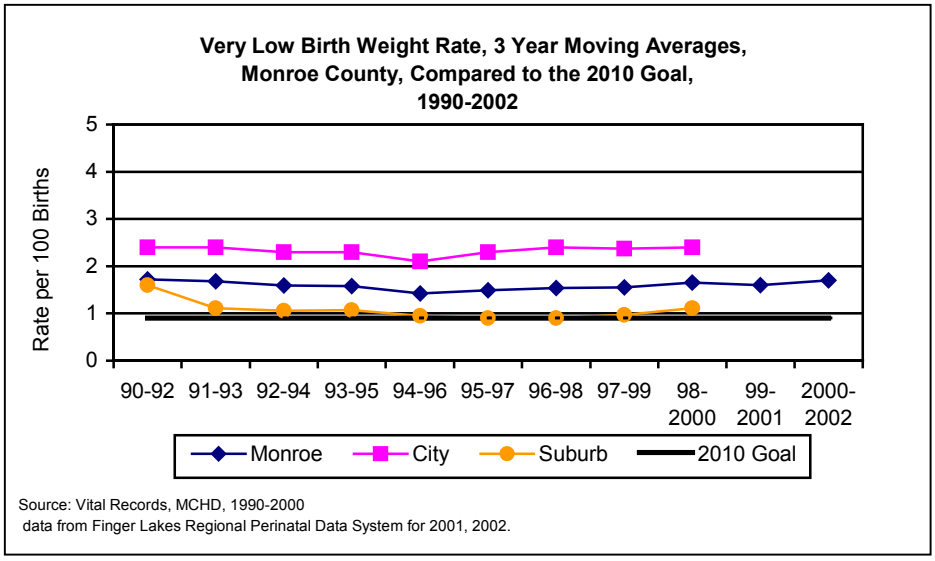
About the data: The rate is calculated by dividing the number of babies born weighing less than 1,500 grams, very low birth weight (VLBW) by the number of live births with a known birth weight. Because VLBW births are a relatively rare occurrence, three-year rates are calculated here to improve the reliability or stability of the data. The sources of the data are Vital Records of the Monroe County Department of Public Health for 1990-2000 and provisional data from the Finger Lakes Regional Perinatal Data System for 2001 and 2002.

In Monroe County:

176 babies with a VLBW were born in 2000. The VLBW rate in Monroe County is comparable to Upstate and NYS and has not met the 2010 Goal.

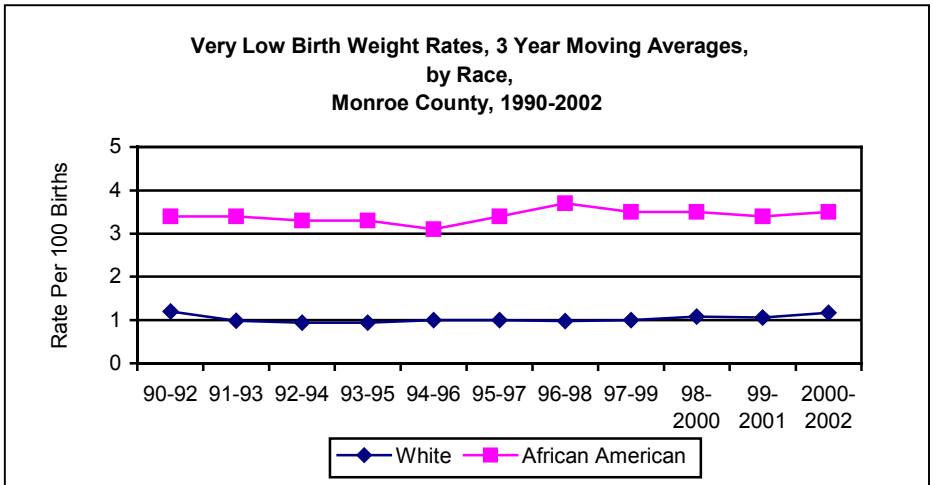
Between 1990 and 2000, the VLBW rate in Monroe County remained relatively stable. The rate in the suburbs decreased slightly.

The VLBW rate in the city is nearly two times higher compared to the rate in the suburbs.



Source: Vital Records, MCHD, 1990-2000
data from Finger Lakes Regional Perinatal Data System for 2001, 2002.

The rate among African Americans is three times higher compared to Whites.



Source: Vital Records, MCPHD, 1990-2000
data from Finger Lakes Regional Perinatal Data System for 2001, 2002.

Premature Births

About the data:. The prematurity rate is calculated by dividing the number of premature births (less than 37 weeks gestation) by the number of live births in which the week of gestation is known. The sources of the data are Vital Records of the Monroe County Department of Public Health for 1990-2000 and provisional data from the Finger Lakes Regional Perinatal Data System for 2001 and 2002.

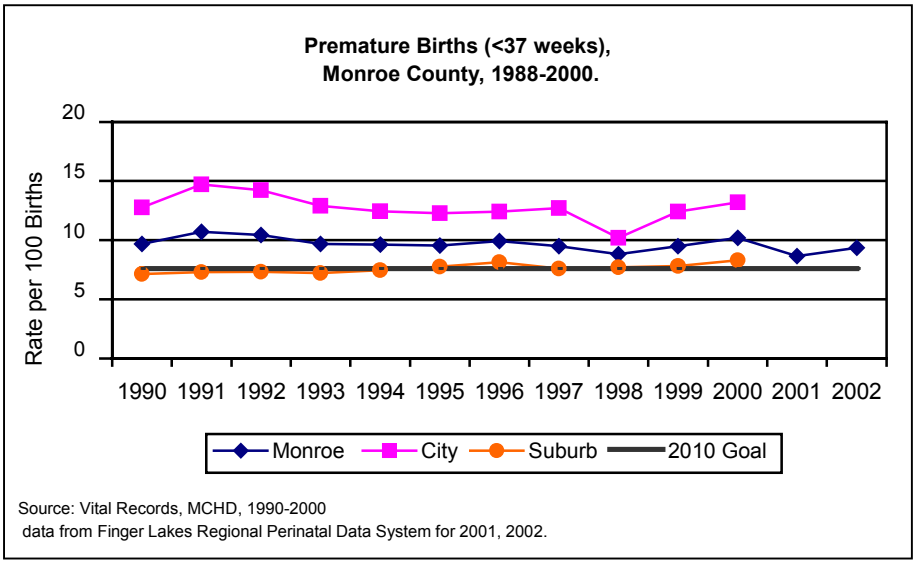
In Monroe County:

858 babies were born prematurely in 2000. The rate of premature births in Monroe County is better than Upstate NY, NYS and the US, but has not met the 2010 Goal.

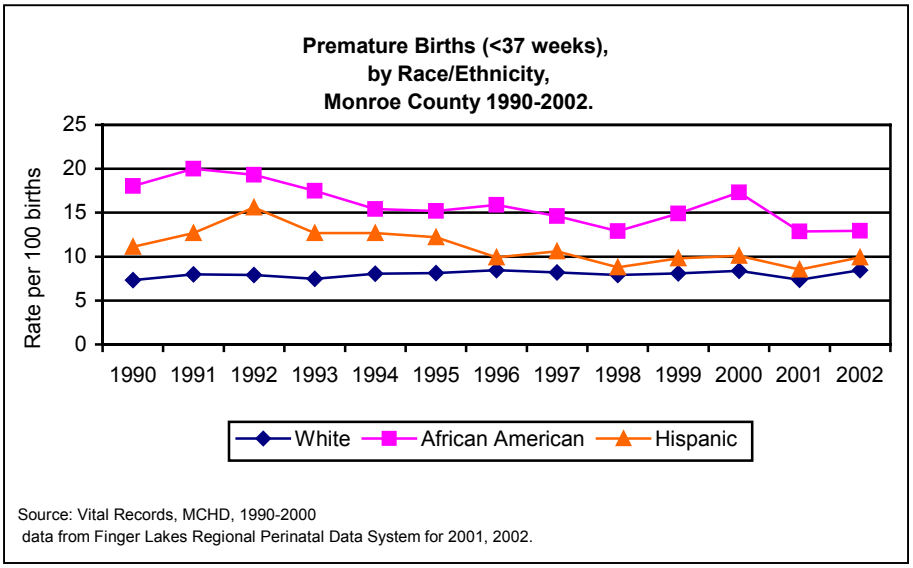
Between 1990 and 2000, the rate of premature births fluctuated in Monroe County as a whole. There was a slight increase in the suburbs, which is most likely due to the increase in the number of babies from multiple births being born early. The prematurity rate among singleton births declined during this time period.

The rate of prematurity is 1.5 times higher in the city compared to the suburbs.

The rate among African Americans is 1.5 times higher than the rate among Whites. The disparities in rates can partly be attributed to economic risks. The prematurity rate among Medicaid recipients and among those without health insurance is nearly two times higher than the rate among those with private or commercial insurance.



Source: Vital Records, MCHD, 1990-2000
data from Finger Lakes Regional Perinatal Data System for 2001, 2002.



Source: Vital Records, MCHD, 1990-2000
data from Finger Lakes Regional Perinatal Data System for 2001, 2002.

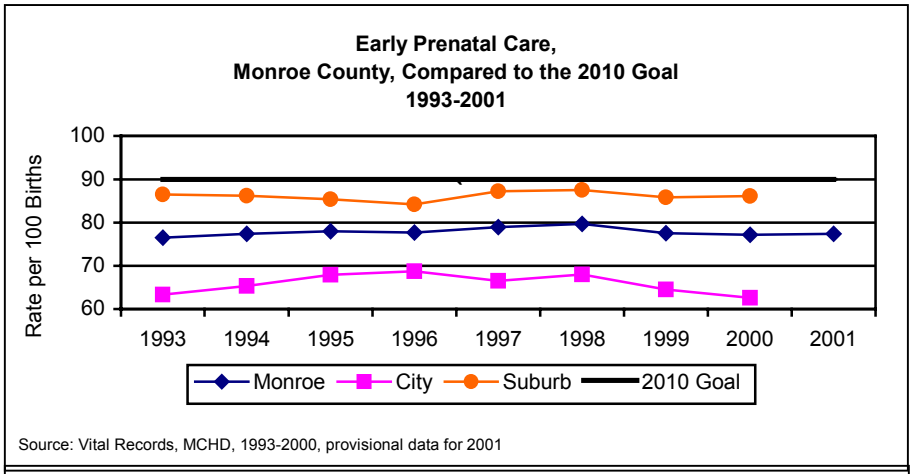
Prenatal Care

About the data: The rate of early prenatal care is calculated by dividing the number of births in which the mother entered prenatal care in the first trimester (i.e. the first three months of pregnancy) by the number of births which the date of entry into prenatal care is known. In 1993 the New York State Health Department changed the way entry into prenatal care was calculated. Therefore data prior to 1993 are not shown here. The data source is Vital Records for the Monroe County Department of Public Health.

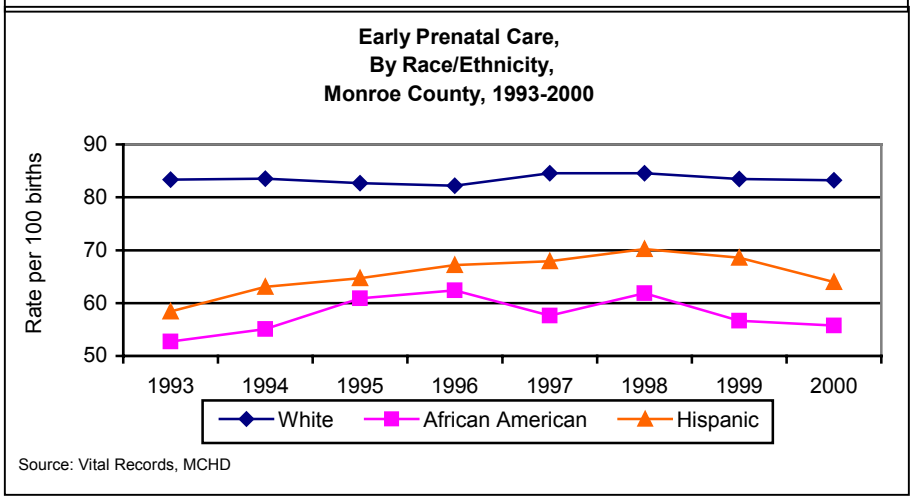
In Monroe County:

In 2000, there were 6,632 (77.2%) births in which the mother entered prenatal care in the first trimester. In the same year, 192 (2.2%) didn't enter care until the third trimester and 399 (4.6%) didn't receive any prenatal care. The rate of early prenatal care in Monroe County is worse than Upstate, better than NYS as a whole, and has not met the 2010 goal for the Nation (90%).

Since 1993, the rate of prenatal care in Monroe County, the city and suburbs fluctuated. The rate in the city is significantly lower compared to the rate in the suburbs.



Source: Vital Records, MCHD, 1993-2000, provisional data for 2001



Source: Vital Records, MCHD

Between 1993 and 2000, the rates of early prenatal care among Whites and African Americans fluctuated. During this same time period, the rate among Hispanics improved overall. The rates among African Americans and Hispanics are significantly lower than the rate among Whites.

The disparities in the rates of early prenatal care are most likely due to economic factors, as the rate among those on Medicaid and those without health insurance is significantly lower than the rate among those with private or commercial health insurance.

HIV Testing

About the Data: This is the percentage of Monroe County residents who gave birth and were tested for HIV status during pregnancy. New York State regulations require that all pregnant women be tested for HIV infection, with informed counseling and consent. Newborns are also screened for the presence of HIV infection. The data source is the New York State Comprehensive Newborn Screening Report, published by the NYS Health Department.

In Monroe County :

In 2001, nearly 95% of residents who gave birth were tested during pregnancy for HIV status. Since 1998 the mother-to-child transmission rate for HIV has been 0%, while the number of HIV seropositive women giving birth has remained fairly constant. In contrast, before 1998, the annual mother-to-child-transmission rate for HIV in Monroe County was 10% or more. Prevention of mother-to-child transmission is most likely due to early and ongoing medical treatment of mothers with HIV infection.

Participation in the WIC Program (Women Infants and Children)

About the data: This is the number of pregnant women and infants who participate in the WIC program. To be income eligible for WIC, a woman or infant must either be enrolled in Medicaid, Food Stamps or Temporary Assistance, or live in a family in which the income is less than 185% of the poverty level. The source of the data is the New York State Health Department.

Of Monroe County Residents:

In 2002, 2,817 women and 3,121 infants participated in the WIC program. The number of women and infants participating in WIC has fluctuated since 1993.

Infants receiving Medicaid or infants that live in families with an income less than 185% of the poverty level are eligible for WIC. In order to estimate whether or not WIC is reaching a majority of eligible infants, we calculated the proportion of infants enrolled in WIC divided by the number of births paid for by Medicaid each year. This proportion has consistently been higher than 100%. Based on this estimate it is believed that a large proportion of eligible infants are enrolled in the WIC Program. It should be noted that there are some infants not enrolled in Medicaid who are eligible for WIC, so there are some limitations to this estimate.

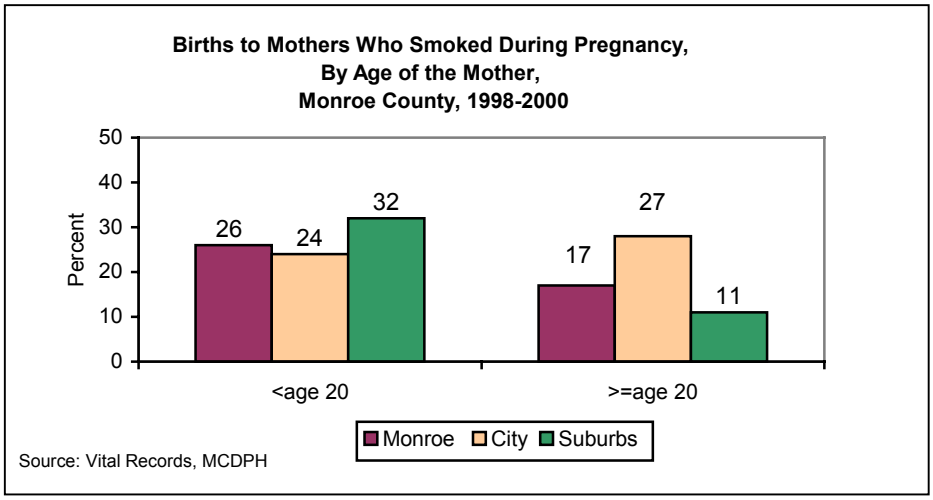
Smoking During Pregnancy

About the data: This is the number and rate of pregnant women who smoked at anytime during their pregnancy. The data originates from the physician's notation in the mother's medical record regarding whether or not she smoked during pregnancy. One limitation of the data is that it only includes women who reported to their physician that they smoked. In addition, the data may include women who smoked early in pregnancy, but quit. The source of these data is Vital Records from the Monroe County Department of Public Health.

In Monroe County :

In 2000, there were about 1,700 births to women who smoked during pregnancy. The rate of smoking during pregnancy (18.1%) remained relatively stable between 1997 and 2000. The rate is similar to rates in Erie and Onondaga counties, and is not at the 2010 Goal (1%).

Rates of smoking during pregnancy are higher among African American (24.5%) and Hispanic (22.4%) residents compared to White (16.7%) residents. Rates are also higher among babies born to teens compared to women 20 and older. Among teens, the rate is higher in the suburbs compared to the city. Among adults the rate is higher in the city compared to the suburbs.

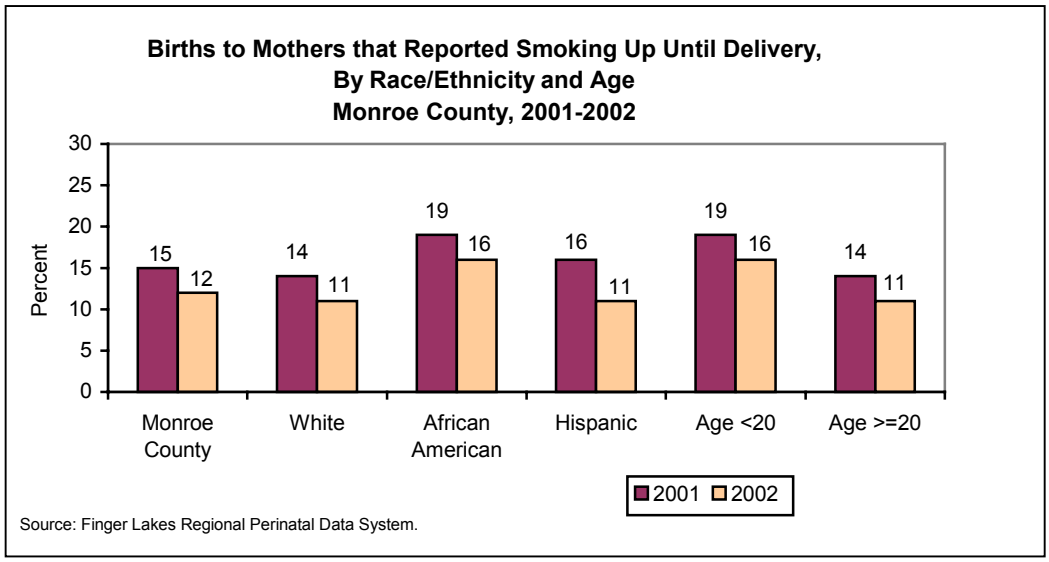


Smoking Status Up Until Delivery

About the data: This is the number and percentage of women who smoked up until delivery and the number and percentage of women who quit smoking during pregnancy. In 2001, the Finger Lakes Regional Perinatal Data System began collecting this information in addition to the birth certificate data detailed on the previous page.

In Monroe County in 2002:

1,025 (12%) women reported smoking up until delivery. Of these women about 600 reported they smoked less than half a pack per day. Smoking rates up until delivery in all groups, except teens, declined significantly between 2001 and 2002. It won't be known if this is a trend until further data becomes available.



Of women who gave birth in 2002, 7% (603) quit smoking while they were pregnant.

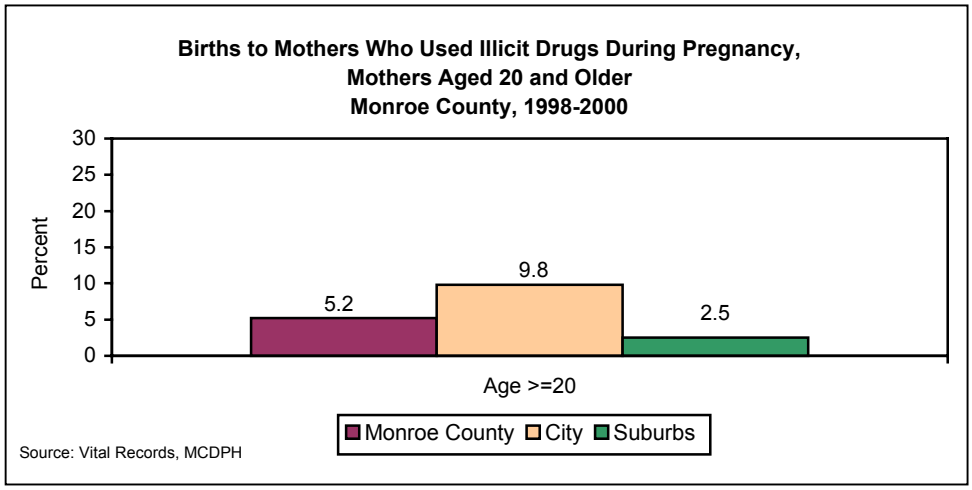
Illicit Drug and Alcohol Use During Pregnancy

About the data: This is the number and percentage births in which the mother used illicit drugs or drank alcohol during pregnancy. The data originate from the physician's notation in the mother's medical record regarding whether or not she used illicit drugs or drank alcohol during pregnancy. One limitation of the data is that it only includes women who are known to have used illicit drugs or drank alcohol during pregnancy. The source of the data is Vital Records from the Monroe County Department of Public Health.

In Monroe County:

Between 1997 and 2000, the overall rate of reported illicit drug use during pregnancy remained relatively stable at about 6% (500 births)

On average each year between 1998 and 2000, 11% of teens used illicit drugs during pregnancy. The rates were not statistically different between city and suburban teens. Among adults, the rate was 5%, with higher rates in the city compared to the suburbs as shown in the chart below.



Rates of illicit drug use are higher among African American (15.7%) and Hispanic (8.9%) residents compared to White (3.0%) residents.

In 2000, the rate of alcohol use during pregnancy was 2.9% (about 300 births). The rate has remained fairly constant since 1997. Rates are higher among city (4.9%) residents compared to suburban (1.5%) residents and among African Americans (5.7%) and Hispanics (4.1%) residents compared to White (2.1%) residents.

The rate of any substance abuse during pregnancy, (either smoking, alcohol and/or illicit drug use) was 20% (1,931 births) in 2000.

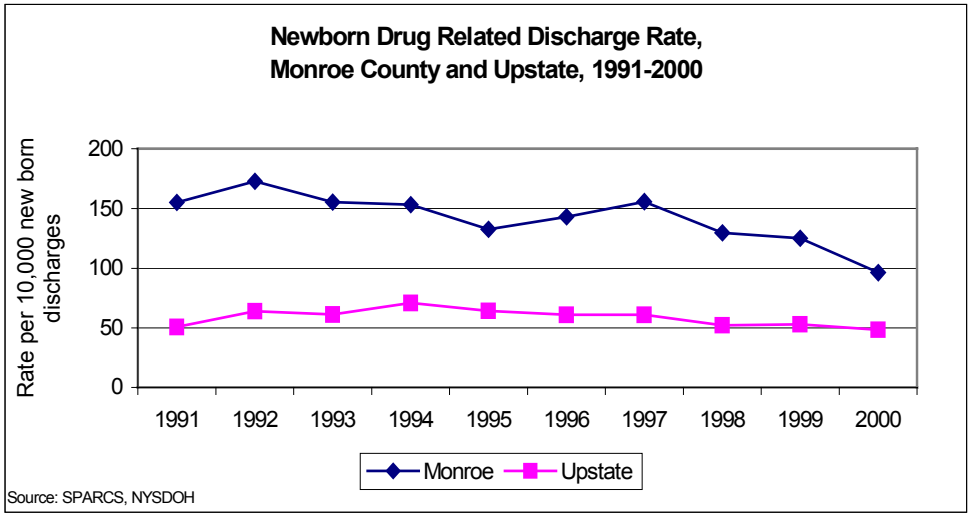
Newborn Drug-Related Hospital Discharges

About the data: This is the number and rate of newborns discharged with a drug-related diagnosis. This data provides another indication of the problem of substance abuse among pregnant women in Monroe County. It is believed that these figures are an under-estimate of the problem. This data only includes infants tested in the hospital. The sensitivity of urine drug tests for each class of drugs is variable. The source of the data is the Statewide Planning and Research Cooperative System (SPARCS) of the New York State Department of Health

In Monroe County during 2000:

83 newborns were discharged from the hospital with a drug related diagnosis.

Since 1991, the rate of newborns discharged with a drug related diagnosis has declined in Monroe County. However, it remains higher than the Upstate rate.

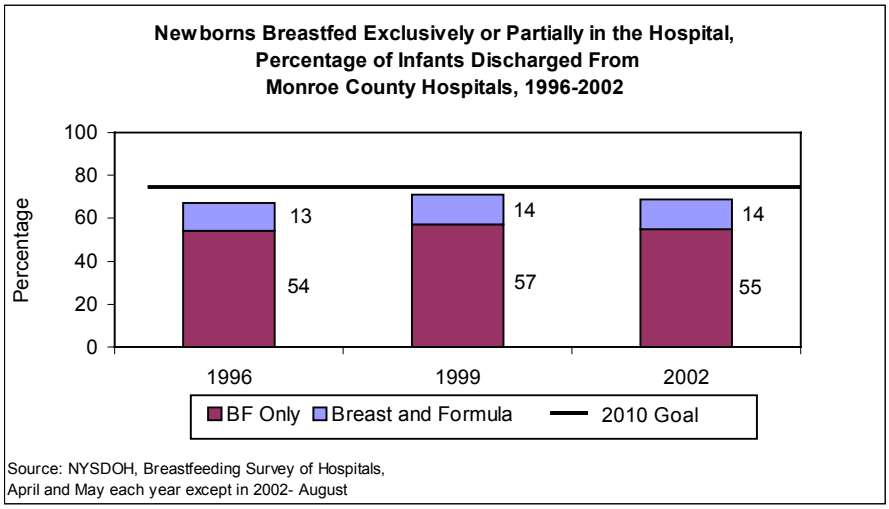


Breastfeeding Rates, Newborns in Hospitals

About the Data: Periodically, the New York State Department of Health conducts the Breastfeeding Survey of Hospitals to determine an estimated rate of breastfeeding during hospitalization. The survey is conducted for one or two months during a given year. The rate is calculated by dividing the number of newborns that were breastfed during hospitalization by the number of newborns discharged from the hospital.

In Monroe County in 2002:

It is estimated that nearly 69% of newborns discharged from hospitals were breastfed during hospitalization. This rate has fluctuated since 1996, is comparable to NYS, and remains below the 2010 Goal (75%).



Source: NYSDOH, Breastfeeding Survey of Hospitals, April and May each year except in 2002- August

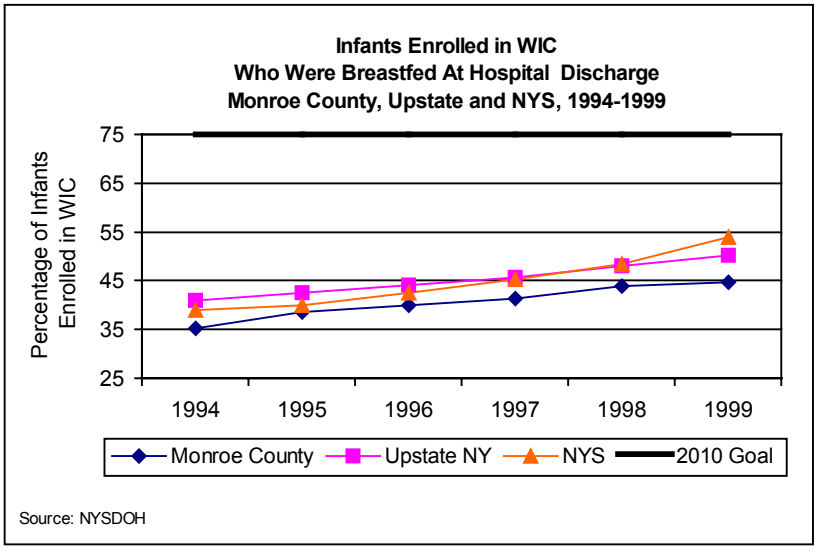
Breastfeeding Rates, Infants Enrolled in WIC

About the data: This is the percentage of infants enrolled in WIC who were breastfed at hospital discharge. Included in this rate are infants who were breastfed partially or exclusively. The source of the data is the WIC Program of the New York State Health Department.

In Monroe County:

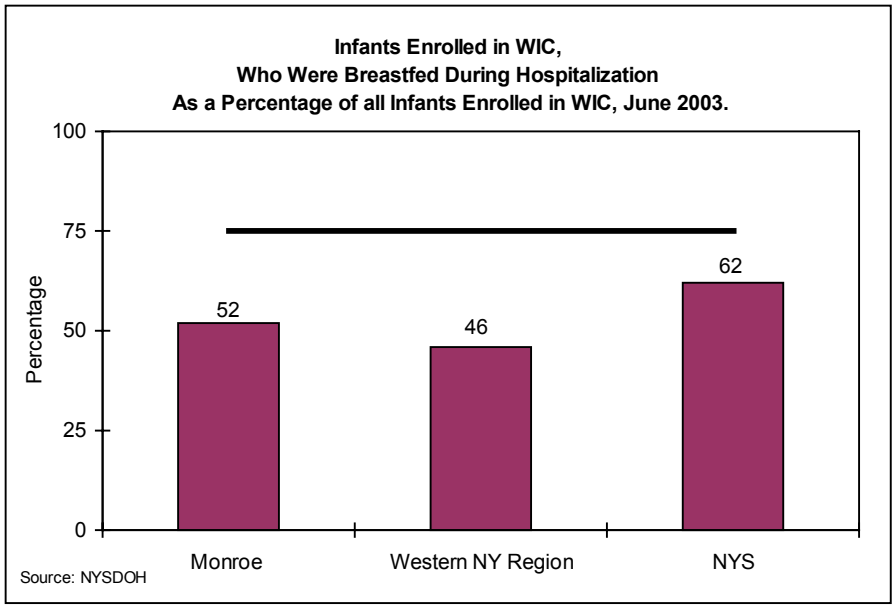
Between 1994 and 1999, the breastfeeding rate at hospital discharge among infants enrolled in WIC increased from 35% to 45%. Rates also increased in Upstate and NYS.

Due to data system changes within WIC, these same data for subsequent years are not available.



Source: NYSDOH

Data from June 2003 show that 52% of infants enrolled in the Anthony Jordan Health Center and Monroe County Health Department WIC Programs were breastfed during hospitalization.[14] This rate is higher than the rate in the Western NY region, but lower than the rate in New York State.

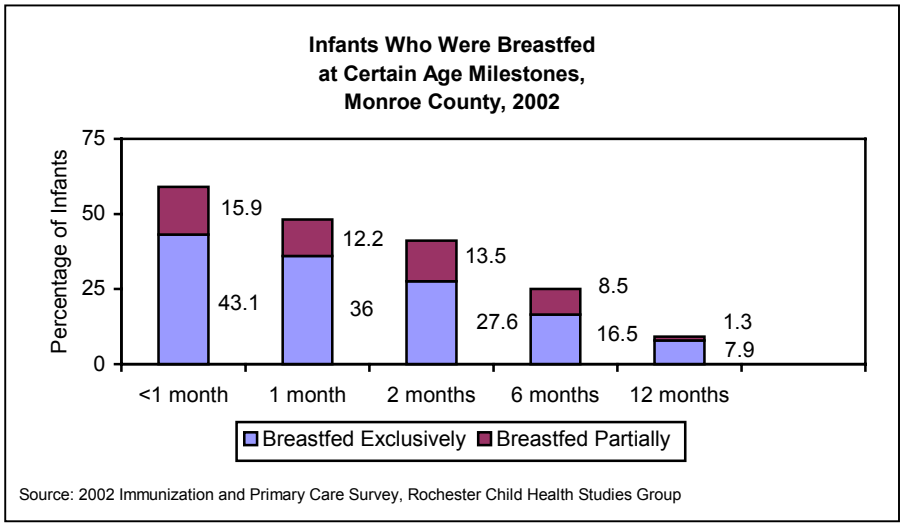


Breastfeeding Duration

About the data: This is an estimate of the percentage of infants who are breastfed at certain ages. The source is the 2002 Immunization and Primary Care Survey, which is a random sample survey of children receiving care in primary care practices in Monroe County.

In Monroe County:

It is estimated that 59% of infants less than one month old are breastfed and by age 6 months, only 25% are breastfed. The Year 2010 Goal is to have 50% of infants breastfeeding at 6 months of age.



[14] Data for two additional sites serving Monroe County residents (Oak Orchard WIC and Finger Lakes WIC) were not included as only a small proportion of their clientel are Monroe County residents.

Emerging Issues Impacting Birth Outcomes and Infant Health:

Since the release of the last Maternal Child Health Report Card in 2000, the health care system in Monroe County experienced significant changes resulting in fewer services available for pregnant women in Monroe County and the City of Rochester, especially for pregnant adolescents.

The most dramatic event occurred in 2001 with the closure of the Genesee Hospital, which included the closure of the third largest obstetrical service in the county. Many obstetricians/gynecologists changed their hospital affiliations and the number of deliveries increased at all the other hospitals. Temporarily, the pressure for staffing and space at these hospitals was overwhelming. Now, two years later, the system has largely adjusted to the loss of a major hospital.

Several other important changes in the health care system have had an impact on pre-natal care and deliveries. In 2002, Anthony Jordan Health Center experienced severe financial problems that required a series of business decisions that resulted in significant service delivery changes. Subsequently, the University of Rochester withdrew the perinatologists from the Jordan obstetrical clinic and Jordan affiliated with Park Ridge hospital for deliveries. The Jordan obstetrical clinic was forced to suspend its perinatal outreach service and the Jordan Teen Center closed.

To make matters worse, the following services for teens were closed in the past two years: Hillside's Opportunity for Parenting Teens, Planned Parenthood's outreach programs and Marshall High School's Even Start Program. In addition, reductions in the Monroe County social services budget caused the reduction in the number of "preventive services" slots available to families at-risk for child abuse and neglect.

It is difficult to determine the impact of these changes on birth outcomes in the community because of other confounding factors. Although the most recent data is from 2000, infant mortality continued to decline throughout the last decade in both the city and the suburbs. At the same time, the rates of low birth weight appeared to be increasing. These curiously conflicting trends may be explained by the increase in the numbers of twin births. The increase in multiple births is largely attributable to the increased availability of fertility services in the community.

On a more positive note, there are some signs of improvement in outcomes related to substance use and HIV in pregnancy. For over a decade, there was a trend toward increasing numbers of babies born to substance abusing women. This trend appears to have stabilized in the past few years with about 80 babies per year testing positive for drug exposure in-utero.

About a decade ago, nearly a dozen HIV infected women would deliver per year at area hospitals and transmission to the baby would occur in about 10% of the cases. In the past few years, perinatal transmission of HIV has been virtually eliminated.

Community Programs to Improve Birth Outcomes and Infant Health

These programs are discussed in the Progress Report for this goal on pages 4-8.

Improve Access to Preventive Health Services

The Importance of Improving Access to Preventive Health Services

Preventive health services, including physician visits, immunizations, dental exams and lead screening, are crucial to maintaining child health. During physician visits, health problems can be identified and treated before they become serious. These visits may also be a time for education and counseling of parents and children on various issues related to child health and well being including injury prevention, nutrition, physical activity, quality child care and behavioral/emotional health. Immunizations given during well child visits promote health by protecting the child from life-threatening illnesses. Regular dental exams result in the early identification and treatment of oral health problems. By identifying children at risk for lead poisoning and regularly testing children to identify those with high blood lead levels, the devastating effects of lead poisoning can be minimized.

A major barrier to accessing preventive health services is a lack of health insurance or inadequate insurance coverage. Therefore, improving health insurance coverage can impact access to preventive care.

Measures of Access to Preventive Health Services

Health Insurance Coverage, Children Entering Rochester City Schools

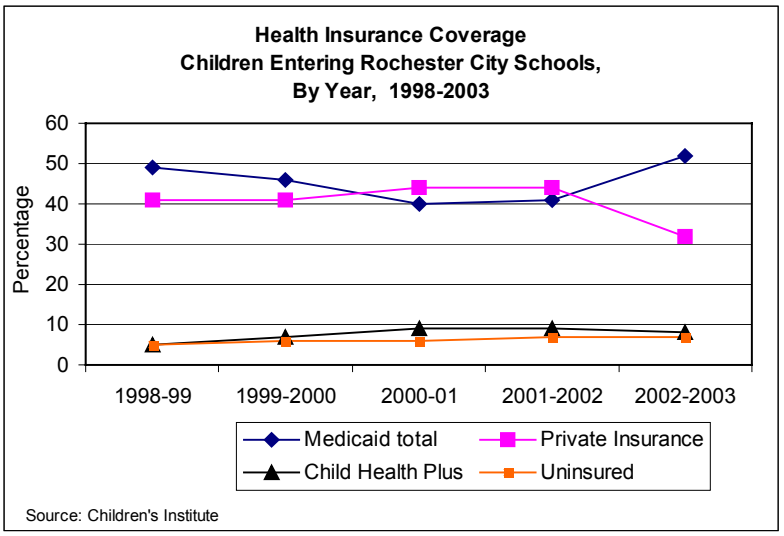
About the data: Each parent or guardian of a child entering Rochester City Schools is asked to complete a survey called PACE (Parent Appraisal of Children's Experiences). The majority of completed surveys are on children entering kindergarten. The Children's Institute Inc. compiles the survey data and publishes an annual report titled, "Community Report on Children Entering School in Rochester, NY." These data are from the 2002-2003 school year. Private insurance is defined as commercial insurance that is paid for by employers and/or the individual.

Parents Surveyed Reported the Following About their Children's Health Insurance Coverage:

- 7% do not have health insurance. This rate is better than the US rate (10.7%)[15] and did not meet the 2010 Goal of 0%.
- 52% are enrolled in Medicaid.
- 32% are enrolled in private insurance
- 8% are enrolled in Child Health Plus.

[15] Census Bureau, Current Population Survey, 2002. Annual Social and Economic Supplement

As shown in the graphic to the right, the proportion of children who are uninsured has remained relatively stable since the 1998-1999 school year. Child Health Plus enrollment has increased slightly during this time. Between the 2001-2002 and 2002-2003 school years, there was an increase in the proportion of children enrolled in Medicaid, and a decrease in the proportion of children enrolled in private insurance.



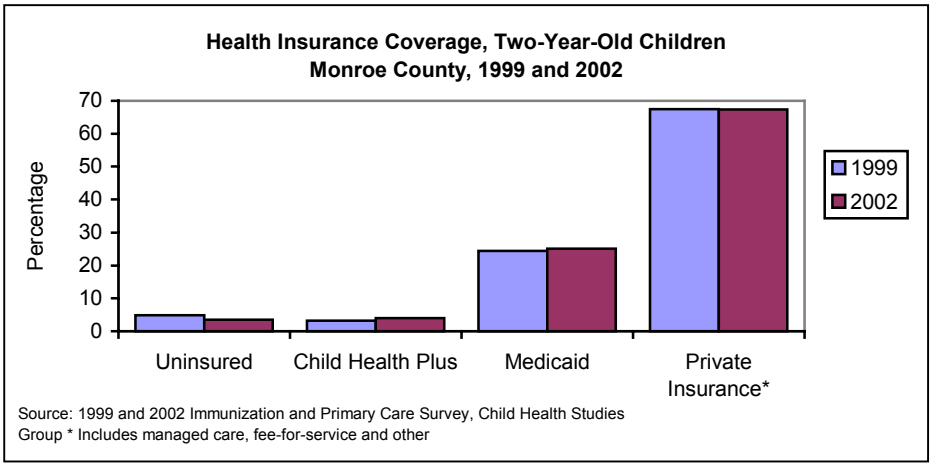
Health Insurance Coverage of Two-Year-Old Children

About the data: This is a point-in-time estimate of the health insurance status of two-year-old children in 1999 and 2002. The source is the Immunization and Primary Care Survey, which is a random sample survey of children receiving care in primary care practices in Monroe County. The inner city is defined as census tracts in which more than 50% of the births were paid for by Medicaid. Private insurance is defined as health insurance paid for by the individual or employer.

It should be noted that these data are more than a year old. Analysis of trends in health insurance coverage since this survey was completed, suggest further declines in private coverage and an increase in Medicaid enrollment due to a poor economy.

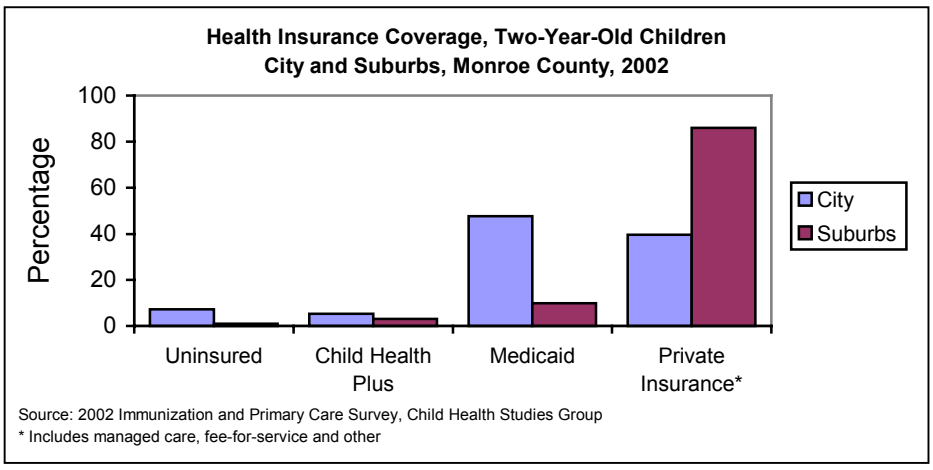
In Monroe County:

In 2002, 3.5% of two-year-old children were uninsured. This rate is better than the US rate (10.7%)[16] but is not at the 2010 Goal (0%). Between 1999 and 2002, several changes occurred in health insurance coverage among 2-year-old children. The uninsured rate decreased from 4.9% to 3.5%. The rate of children enrolled in Child Health Plus increased from 3.2% to 4%. Medicaid enrollment and private insurance did not significantly change.



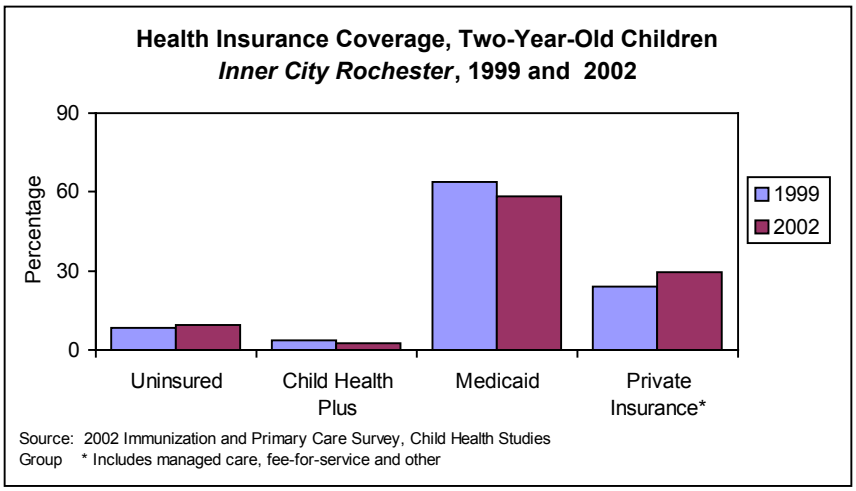
[16] Census Bureau, Current Population Survey, 2002. Annual Social and Economic Supplement

The uninsured rate along with the rate of enrollment in Child Health Plus and Medicaid, are higher in the city compared to the suburbs. The majority of suburban two-year-old children are enrolled in private insurance.



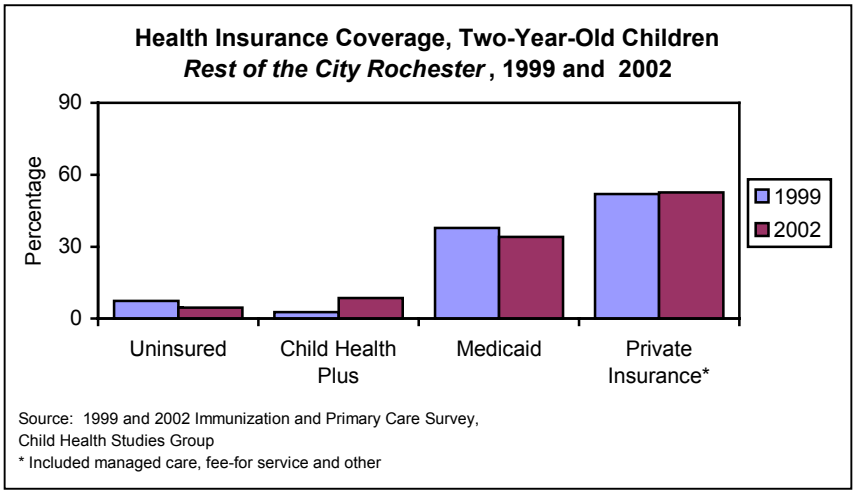
Source: 2002 Immunization and Primary Care Survey, Child Health Studies Group
* Includes managed care, fee-for-service and other

Between 1999 and 2002 the uninsured rate of two-year old children in the inner city remained the same, at about 9%. Enrollment in Medicaid and Child Health Plus decreased, while enrollment in private insurance coverage increased.



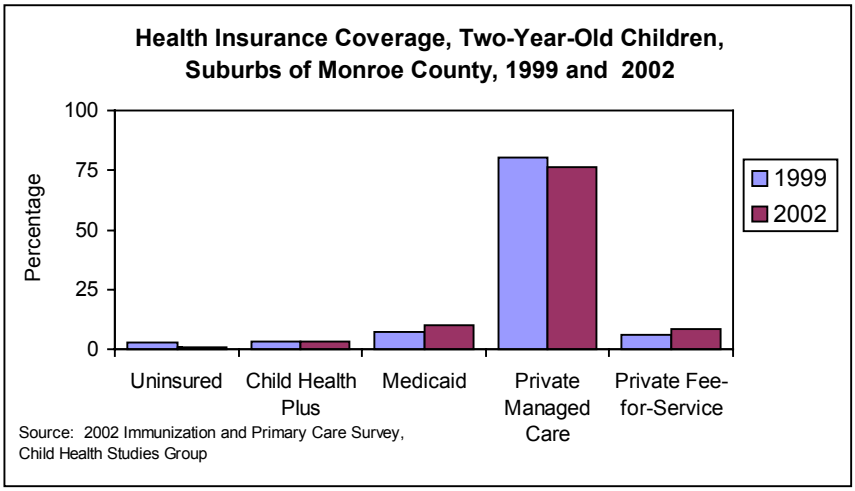
Source: 2002 Immunization and Primary Care Survey, Child Health Studies Group * Includes managed care, fee-for-service and other

Within the rest of the city, the rate of uninsured two-year-old children decreased, to about 5%. Enrollment in Medicaid decreased, while enrollment in Child Health Plus increased significantly. Private insurance enrollment remained about the same.



Source: 1999 and 2002 Immunization and Primary Care Survey, Child Health Studies Group
* Included managed care, fee-for service and other

In the suburbs, there was an increase in private-fee-for service coverage, while private managed care enrollment declined. The uninsured rate decreased. Enrollment in Medicaid increased, while enrollment in Child Health Plus remained about the same.

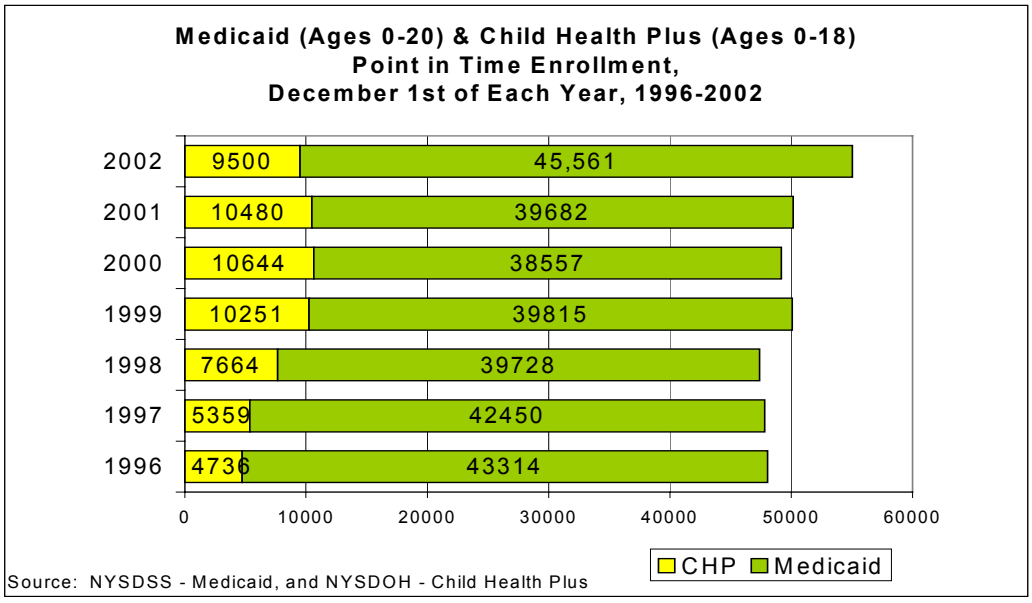


Publicly Funded Health Insurance

About the data: This is the number of children under age 21 receiving Medicaid and the number of children under age 19 receiving Child Health Plus (CHP), as of December 1st of each year. The sources of the data are the New York Department of Social Services (Medicaid), and New York State Department of Health (Child Health Plus).

In Monroe County in 2002:

55,061 children aged birth to 20 were enrolled in either Medicaid or Child Health Plus. This number increased between 1996 and 2002. The 9% decline in the number of children enrolled in CHP that occurred between 2001 and 2002 was most likely due to the fact that children enrolled in CHP who were eligible for Medicaid, were moved to Medicaid.



Well Child Visits, Children Enrolled in Managed Care Programs

About the data: The New York State Department of Health publishes an annual report on managed care plan performance called the New York State Managed Care Performance Report. The table below shows the percentage of children receiving well child visits within the recommended time frame as reported by managed care insurance programs in the Rochester Area. Note that data on commercial plans and Medicaid/Child Health Plus come from different sources, so they are not comparable.

In the Rochester Area:

More than 90% of children enrolled in commercial managed care programs receive well child visits in the recommended time frame. Among the Medicaid population, rates vary by insurer.

Well Child Visits Within Recommended Time Periods, Children Enrolled in Managed Care Programs in the Rochester Region, In {2001 or 2002}, Compared to the Statewide Average ( ).

	Blue Choice Commercial {2001}	Preferred Care Commercial {2001}	Blue Choice Option Medicaid {2002}	Preferred Care Medicaid {2002}	Child Health Plus {2002}
5 or more well child visits in the first 15 months of life for children who were continuously enrolled in the plan from 31 days old.	93%▲ (83%)	98%▲ (83%)	66%▼ (72%)	85%▲▲ (72%)	84%▲▲ (67%)
At least 1 well child visit annually, children ages 3-6yrs for children who were continuously enrolled in the plan during the reporting year.	86%▲ (75%)	88%▲ (75%)	79%▼ (81%)	81% (81%)	82%▲▲ (75%)

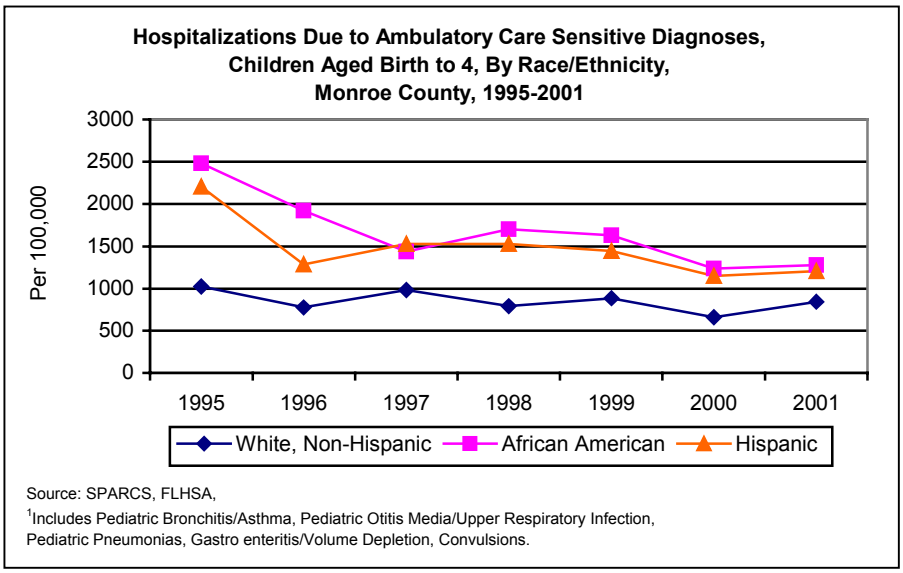
Source: 2002 New York State Managed Care Plan Performance, NYSDOH.
▲ =significantly better than the New York State average in 2001
▲▲ =significantly better than the New York State average in 2001 and 2000
▼ =significantly worse than the New York State average in 2001

Hospitalizations Due to Ambulatory Care Sensitive (ACS) Diagnoses

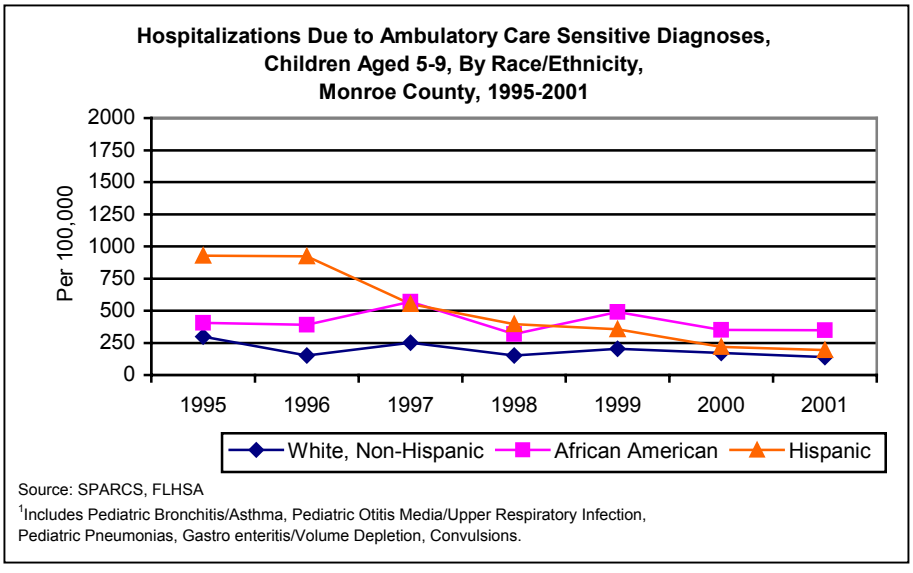
About the data: This is the rate of hospitalizations due to ACS diagnoses. ACS diagnoses are defined as those conditions for which timely and effective primary care can help to reduce the risk of hospitalizations. In this report, ACS hospitalizations for children include: pediatric bronchitis/asthma; pediatric otitis media; upper respiratory infection; pediatric pneumonias; gastroenteritis/volume depletion; and convulsions. The source of the data is the Statewide Planning and Research Cooperative System (SPARCS) of the New York State Department of Health.

In Monroe County:

Rates of hospitalizations due to ACS diagnoses are significantly lower than the rates in Upstate NY as a whole. The rates in Monroe County among children, birth to age 4 and age 5-9, declined significantly between 1995 and 2001. Within the birth to age four group, there was a reduction in the disparity of rates between Whites, African Americans and Hispanics. Within the 5-9 age group, there was a reduction in the disparity between Whites and Hispanics only.



Source: SPARCS, FLHSA,
[1]Includes Pediatric Bronchitis/Asthma, Pediatric Otitis Media/Upper Respiratory Infection, Pediatric Pneumonias, Gastro enteritis/Volume Depletion, Convulsions.



Source: SPARCS, FLHSA
[1]Includes Pediatric Bronchitis/Asthma, Pediatric Otitis Media/Upper Respiratory Infection, Pediatric Pneumonias, Gastro enteritis/Volume Depletion, Convulsions.

"Up-to-Date" on Immunizations

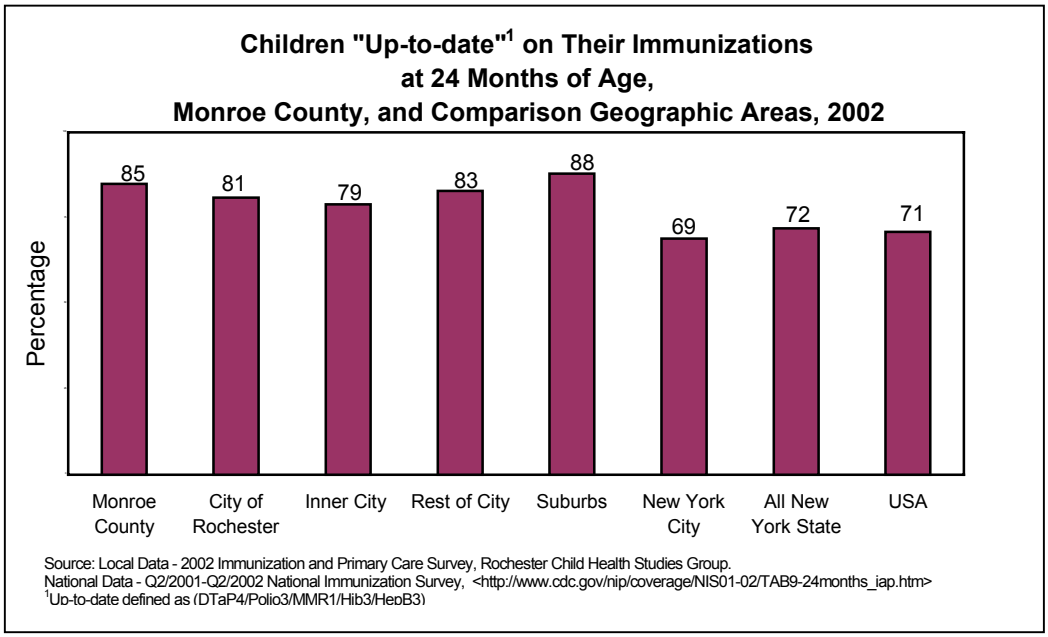
About the data: This is the estimated percentage of children who are up-to-date on their immunizations at 24 months of age. "Up-to-date" is defined as 4 DTaP, 1MMR, 3 Polio, 3 Hib, and 3 Hepatitis-B shots. The source of local data is the 2002 Immunization and Primary Care Survey. The source of state and national data is the Q3/2001-Q2/2002 National Immunization Survey performed by the National Immunization Program, the National Center for Health Statistics and the Centers for Disease Control and Prevention.

The 2010 Goal is to have 90% of 19-35 month old children "up-to-date" on their immunizations. At the writing of this report, local data are only available for children at 24 months of age. In the future, the Rochester Child Health Studies Group will release a report that compares Monroe County rates to the 2010 Goal.

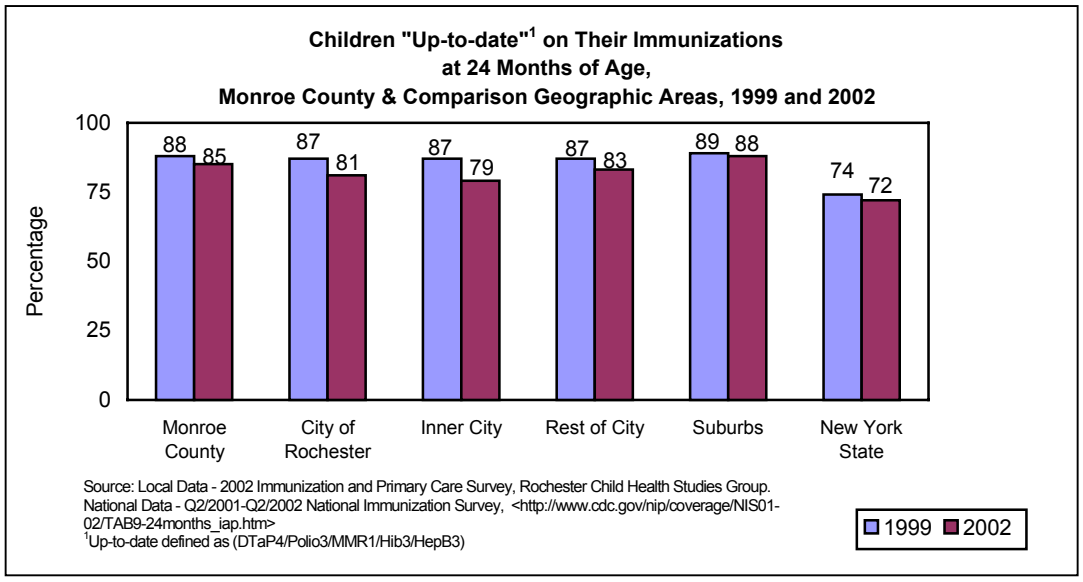
In Monroe County:

85% of children in 2002 were "up-to-date" on their immunizations at 24 months of age. The rate is significantly higher in the suburbs compared to the city. The rate in the inner city is significantly lower than rate in the rest of the city.

Rates in Monroe County, the City of Rochester and the suburbs are higher than rates in New York City, New York State and the US. This could be attributable to the highly collaborative immunization effort within Monroe County that involves a partnership with the three health systems, the two Medicaid Managed Care Insurers, the Monroe County Department of Public Health and city-based primary care providers.



As shown in the graphic on the next page, between 1999 and 2002, up-to-date immunization rates declined throughout all areas of Monroe County, and also in New York State. During this time period, the rate in the inner city declined more than the suburbs.



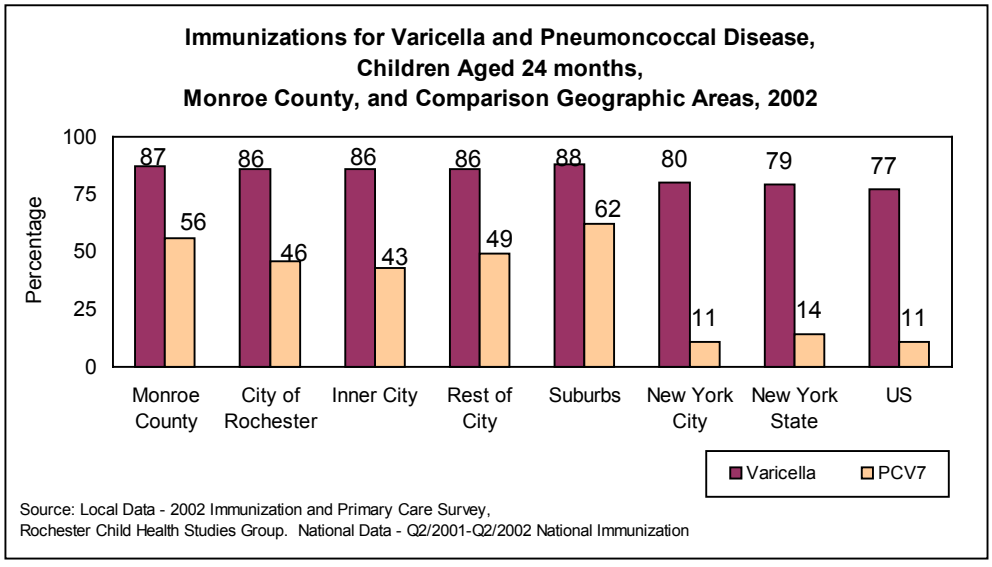
Factors contributing to the declines in Monroe County, and to the steeper declines in the city, include: vaccine shortages during this time period; staffing and system challenges within several primary care practices serving the City of Rochester; and temporary staffing shortages in the Primary Care Outreach Program; which focuses on getting the area's highest risk children immunized.

Varicella and Heptavalent Pneumococcal Conjugate Vaccines

About the data: This is the percentage of children who have received their varicella vaccine and 3 heptavalent pneumoccoccal conjugate vaccines (PCV7). These two vaccines are not included in the national standard definition of up-to-date immunizations because they are fairly new to the recommended schedule. The source of local data is the 2002 Immunization and Primary Care Survey. The source of state and national data is the Q3/2001-Q2/2002 National Immunization Survey performed by the National Immunization Program, the NCHS and the CDC.

In Monroe County:

Immunization rates for both of these vaccines are higher compared to the rates in New York State and the US. For these two vaccines, rates in the city are as high as rates in the suburbs.

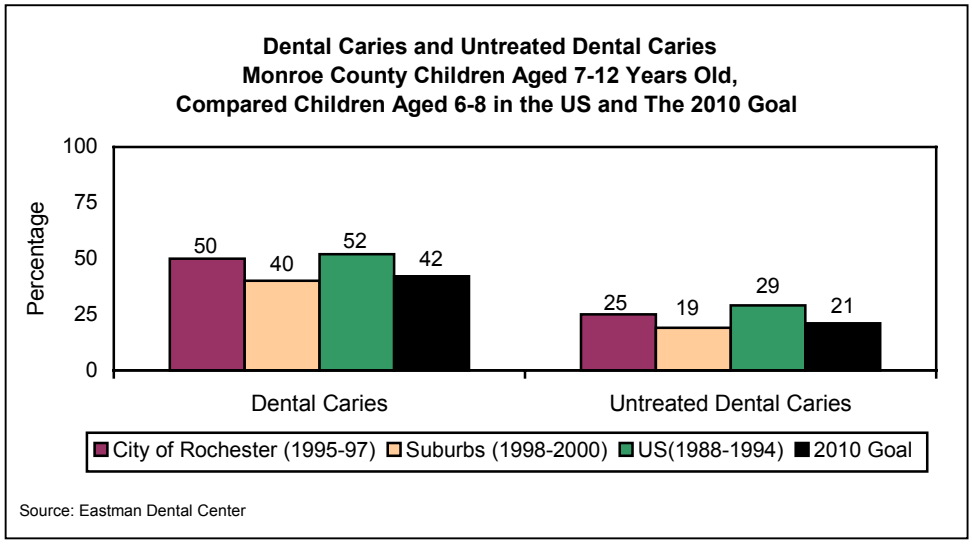


Oral Health Status of Monroe County School Children

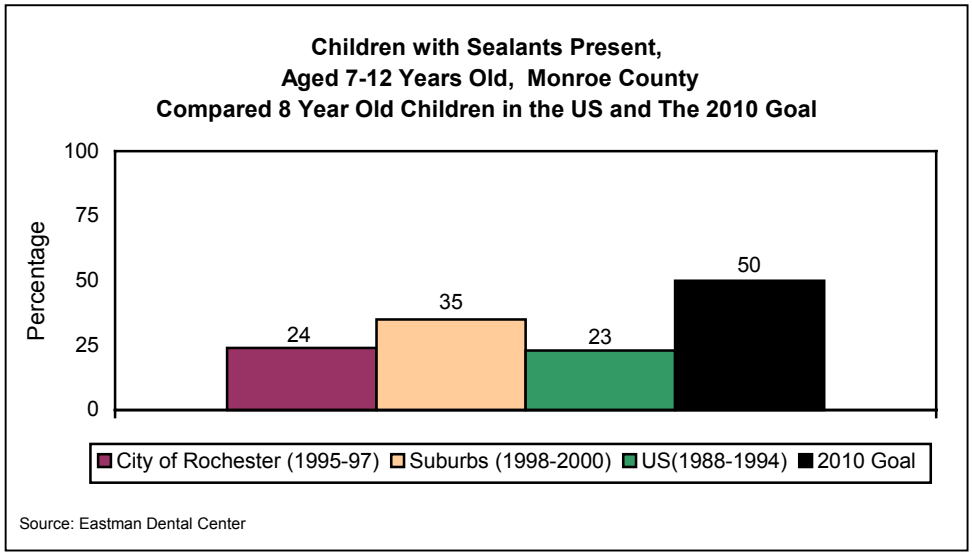
About the data: This is the percentage of children with dental caries, untreated caries and the percentage who have dental sealants. The source of the data is the Monroe County Dental Health Survey conducted by the Eastman Dental Center. This surveillance program conducts dental examinations in a random sample of children in both city and suburban schools.

In Monroe County:

The oral health status of school children has improved significantly since the surveillance program began in 1988. Despite improvements in oral health status among city and suburban children, there remain significant disparities in the rates of dental health problems. As shown in the table below, 50% of children in the City School District have at least one cavity and 25% have at least one untreated cavity. These rates are well above the 2010 Goals, while rates in the suburbs have met the 2010 Goals.



The rate of city children receiving protective sealants is close to that of US children, but is lower than the rate in the suburbs (35%) and the 2010 Goal (50%).



Access to Dental Care – Children Entering Rochester City Schools

About the data: The source of these data is the PACE Survey for the 2001-2002 school year, compiled by Children's Institute.

Parents Surveyed Reported the Following About their Children's Dental Care:

- 20% had *never* seen a dentist for a check-up or for dental work.
- 34% *do not* have a dentist.
- 69% had seen a dentist in the past year for either a check up or dental work. This rate exceeded the 2010 Goal of 56%.

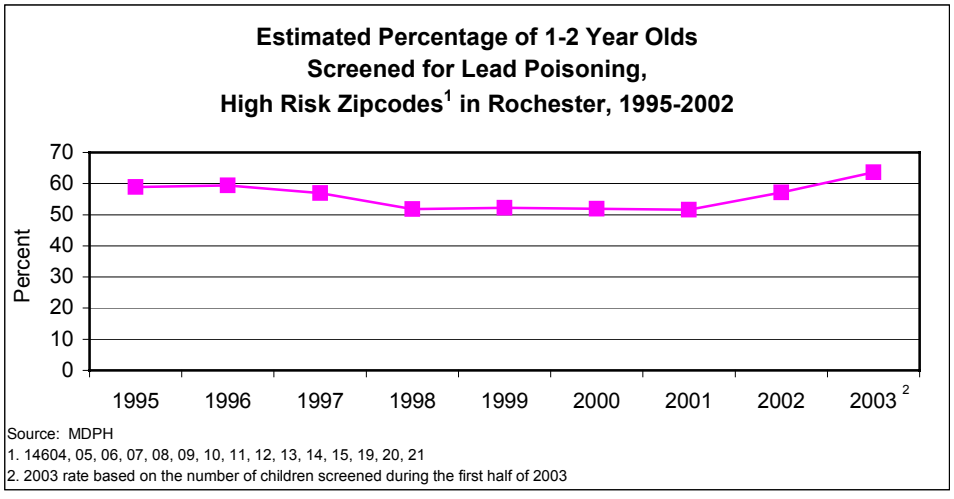
Screening (Testing) for Lead Poisoning

About the data: The New York State Health Department requires that all children be screened for lead poisoning at ages 1 and 2. Primary health care providers also must assess each child between 6-72 months of age for high dose lead exposure and each child found to be at risk should be screened. High-risk children often live in, or regularly visit a house or other building, that was built before 1950, that has either peeling or chipping paint or that has recently or is undergoing renovation or remodeling. According to the 2000 Census, 64% percent of the houses in the City of Rochester were built before 1950; therefore they are likely to contain lead paint.

Lead screening is tracked by the Lead Poisoning Prevention Program of the Monroe County Department of Public Health. The chart below illustrates the estimated percentage of children residing in high risk Rochester zip codes, who were screened for lead poisoning. Since there are not population estimates for 1 and 2 year old children by these high risk areas, the numbers of births in these zip codes for the previous 2 years were used to calculate rates. These population estimates may be higher than the actual population numbers, because they do not take into account migration from the city to the suburbs

In High Risk Zip Codes in the City of Rochester:

The rate of screening for lead poisoning declined between 1995 and 2001, then increased in 2002. *Estimates* for 2003 based on the number of children screened during the first half of the year, indicate that the percentage may also increase in 2003.



Source: MDPH
1. 14604, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 19, 20, 21
2. 2003 rate based on the number of children screened during the first half of 2003

One factor that may have contributed to the decline in screening rates during the late 1990s and 2000, is confusion among some providers about the recommendations regarding who should be screened.[17] The New York State Health Department recommends that all children be screened for lead poisoning at age 1 and 2. The Centers for Disease Control and Prevention currently recommends targeted screening. Another factor contributing to the decline may have been system challenges within several primary care practices serving the city of Rochester during this time.

Screening for Lead Poisoning, Medicaid Managed Care Programs and Child Health Plus

About the data: This is the percentage of two-year old children enrolled in Medicaid managed care programs or the Child Health Plus Program that were screened for lead poisoning. The source is the New York State Managed Care Performance Report.

In the Rochester Region:

More than 80% of two-year-old children enrolled in Medicaid Managed Care, through Blue Choice Option or Preferred Care, had their blood tested for lead poisoning in 2002. Sixty-nine percent of two-year-old children enrolled in Child Health Plus had their blood tested. These rates have remained relatively stable since 1999.

Two-Year-Old Children Tested for Lead Poisoning, Children Enrolled in Managed Care Programs in the Rochester Region, Compared to the Statewide Average ( ), 2002

Child Health Plus	Blue Choice Option Medicaid	Preferred Care Medicaid
67% (68%)	80%▲▲ (74%)	81%▲ (74%)

Source: 2002 New York State Managed Care Plan Performance, NYSDOH.
▲▲ = significantly better than the New York State average in 2000 and 2001
▲ = significantly better than the New York State average in 2001

[17] "New York State Department of Health Response to CDC' Morbidity and Mortality Weekly Report 9/12/03 "Surveillance for Elevated Blood Lead Levels among Children – United States, 1997-2001.

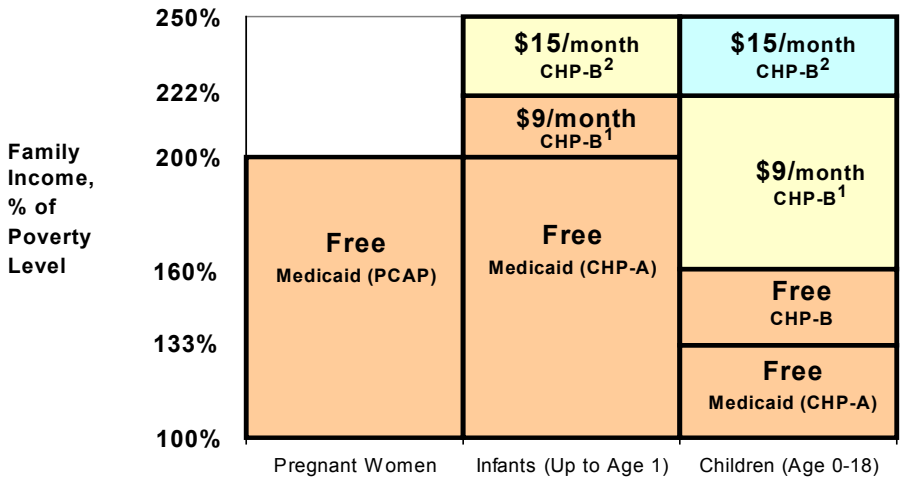
Emerging Issues Impacting Access to Preventive Health Services

Health Insurance

During the last decade, great strides were made in increasing the level of health insurance coverage for children at the national, state and local levels. In the last few years the downturn in the economy and changes in the health insurance benefits provided by employers have offset these improvements.

A series of changes in the Medicaid Program at the federal and state levels, the passage of the federal SCHIP legislation and the support for the facilitated enrollment program all contributed to recent improvements in health insurance coverage for children in our community. The graphic below illustrates the eligibility guidelines for these publicly funded health insurance programs.

Government Subsidized Health Insurance Programs, New York State, 2003



[1]Per Child, per month with a maximum $27 per family
[2]Per Child per month with a maximum of $45 per family

In the past 2-3 years, several economic factors have threatened the effort to achieve the goal of health insurance coverage for 100% of children in our community. The economic downturn in 2002 and 2003 at the national level has caused a reduction in employment at the national level. The economic impact of this downturn has hit upstate New York cities especially hard.

Local businesses have adapted to the economic downturn and the increasing cost of health insurance by passing along a larger portion of the health insurance cost to employees. This has forced some near-poor families to drop their employer sponsored health insurance coverage. Other near-poor families may be keeping their employer sponsored insurance but choosing a less comprehensive coverage plan. It is likely that some of these families have determined that they are better off dropping employer sponsored coverage and opting for government subsidized plans such as Child Health Plus B and Family Health Plus.

In addition, in the last few years, several local employers have elected to become "self-insured." This allows them to provide health care coverage at a lower cost, but frequently lowered cost is associated with fewer benefits. Since these plans are outside the traditional health insurance system, very little data is available about this type of health care coverage, the benefit packages and the health services provided.

Several national businesses that are self-insured and have local employees have elected to provide very constrained benefits. For example, employees have chosen or discovered that their plans for their children do not include coverage for childhood immunizations. This alarming trend could have serious consequences for local "up-to-date" immunization rates.

The increasing cost of the local share of the cost of the Medicaid Program has placed extreme pressure on the Monroe County government budget. As a cost savings measure, Monroe County reorganized its social services programs in 2002. The Medicaid eligibility determination process was integrated with other social services programs. Increasing case loads related to economic factors may have offset any gains in efficiency associated with the reorganization.

Access to Dental Care

Sparked by the release of a Report by the Surgeon General in 1997, there has been a nation-wide resurgence of interest in access to dental health services for all children and the elimination of disparities in dental health outcomes. While many factors contribute to poor access and disparities, reimbursement rates for dental health services have been viewed traditionally as an important determinant. In New York State, several changes have occurred in reimbursement rates in government sponsored programs for dental services that hold great promise to improve access and reduce disparities.

In 2001, a decision was handed down in a lawsuit brought by the NYS Dental Association on behalf of dentists working in office settings serving children in the Medicaid fee-for-service program. The decision resulted in a substantial increase in reimbursement levels, nearly matching private fee for service levels. One of the principle arguments for the increases was that if the State raised reimbursement levels, more dentists would participate in the Medicaid program. Unfortunately, that has not happened. The number of dentists participating in these programs remains low, in the 10 to 12% range.

Unfortunately, there have been no substantial changes in the rates paid by NYS for dental services provided in Article 28 diagnostic and treatment centers. Low reimbursement rates in these settings continue to exist because NYS has focused its strategy on improving access to health services by supporting transitions of large numbers of poor patients into managed care plans rather than raising the rates in these centers. However, it is rare that dental health services are offered as part of the benefit package in Medicaid managed care in upstate NY. The stumbling block has always been the inability to put a panel of dentists together to serve Upstate NY.

Child Health Plus B offers dental health services in Monroe County. Based on strong advocacy by the Rochester Oral Health Coalition, Excellus Blue Cross of the Rochester Region has raised the reimbursement rates for this program nearly matching private fee-for-service levels.

Community Programs to Improve Access to Preventive Services

These programs are discussed in the Progress Report for this goal on pages 9-11.

Minimize the Impact of Asthma

The Importance of Minimizing the Impact of Asthma

Asthma is the most common chronic disease of childhood. Poorly controlled asthma can negatively impact a child's health and daily functioning, including attending school and participating in physical activities. Effective management of asthma includes the control of exposure to environmental triggers (such as cigarette smoke and allergens), appropriate medication, regular monitoring by the health care provider and education for both parents and patients about controlling asthma.

Measures of Asthma's Impact

Asthma Prevalence - Children Entering Rochester City Schools

About the data: The source of these data is the PACE Survey, from the 2001-2002 school year, compiled by Children's Institute.

Parents Surveyed Reported the Following About their Children's Health:

- 14% have asthma

Asthma Prevalence – Rochester City School District, Pre-K through 8th Grade

About the data: This is the percentage of children enrolled in public, and charter schools, who have been diagnosed by their physician with asthma and have reported this diagnosis to the school nurse during the 2002-2003 school year. This data is most likely an underestimate of the number of children with asthma. There may be children who have been diagnosed, but the school nurse was not notified. In addition, there may be students who have asthma, but have not gone to the doctor for a diagnosis. The definition of poorly controlled asthma includes one or more of the following: routinely uses Albuterol more than 2 times per week, limits physical activity because of asthma symptoms, is hospitalized or visited the emergency room for asthma during the current school year, has absences due to asthma, has asthma symptoms at school but medication is not available. The source of the data is the Regional Community Asthma Network of the Finger Lakes (RCAN).

Of Students in Rochester Public and Charter Schools in Pre-K through 8th Grade:

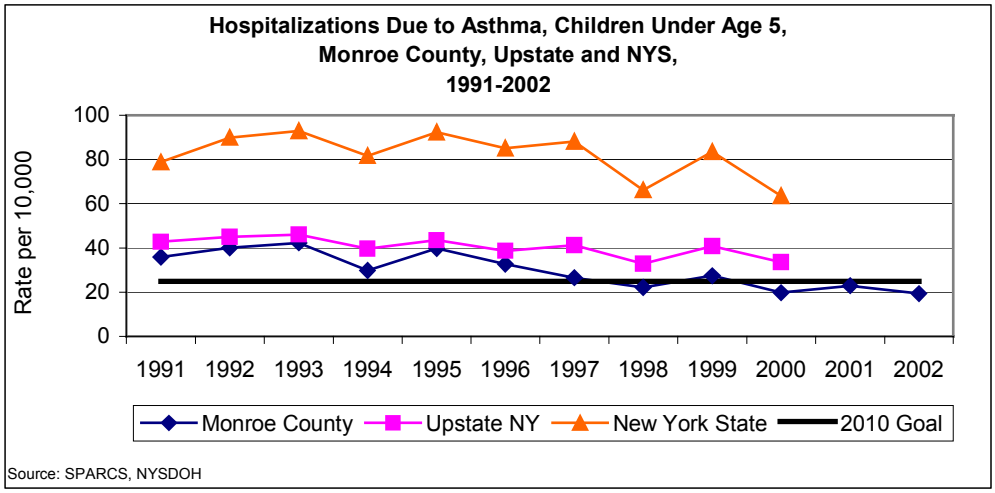
- 10% have been diagnosed with asthma. Of those students with diagnosed asthma, 7% of them have an asthma action plan on file in the school and 3.2% are poorly controlled based on the school nurse's assessment.

Hospitalizations Due to Asthma

About the data: This is the number and rate of hospital discharges with a principal diagnosis of asthma. The principal diagnosis is defined as the condition chiefly responsible for hospital admission. Outpatient or emergency room visits are not included in the data. The source of the data is the Statewide Planning and Research Cooperative System (SPARCS) of the New York State Department of Health.

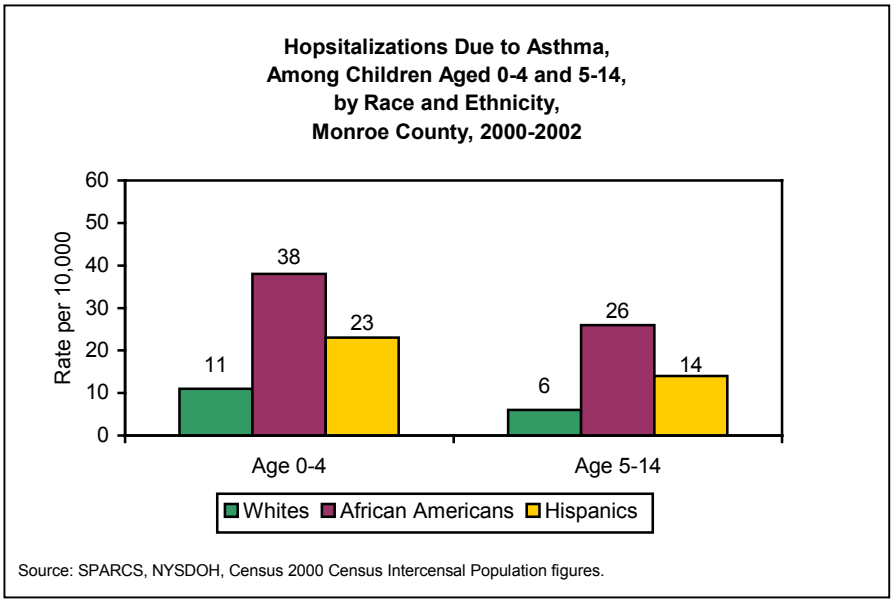
In Monroe County:

There were 91 hospitalizations due to asthma among children under age 5 in 2002. The rate of asthma hospitalizations in this age group has declined significantly since 1991, and in 2000, the rate achieved the Year 2010 Goal. Hospitalization rates due to asthma among this age group in Monroe County are better than rates in Upstate and New York State.

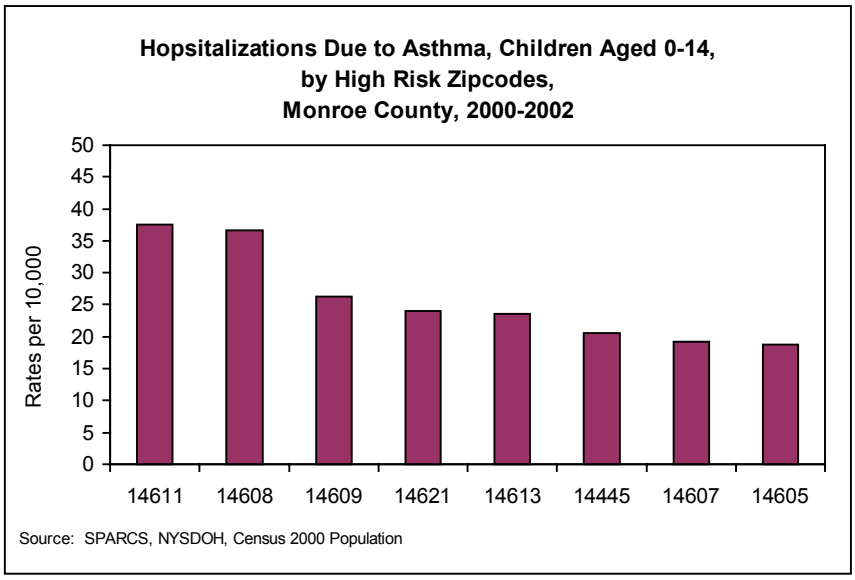


In 2002, there were 101 hospitalizations due to asthma among children aged 5-14 years old in Monroe County. The rate of hospitalization due to asthma declined significantly between 1991 and 2000. There is not a specific Year 2010 Goal for this age group. Hospitalization rates due to asthma in Monroe County are similar to Upstate, but lower than New York State.

Rates of asthma hospitalization are three to four times higher among African Americans and two to three times higher among Hispanics compared to Whites.



The graphic to the right shows zip codes in Monroe County in which rates of hospitalization due to asthma among children are the highest. These rates are well above the total county rate of 14.9/10,000.



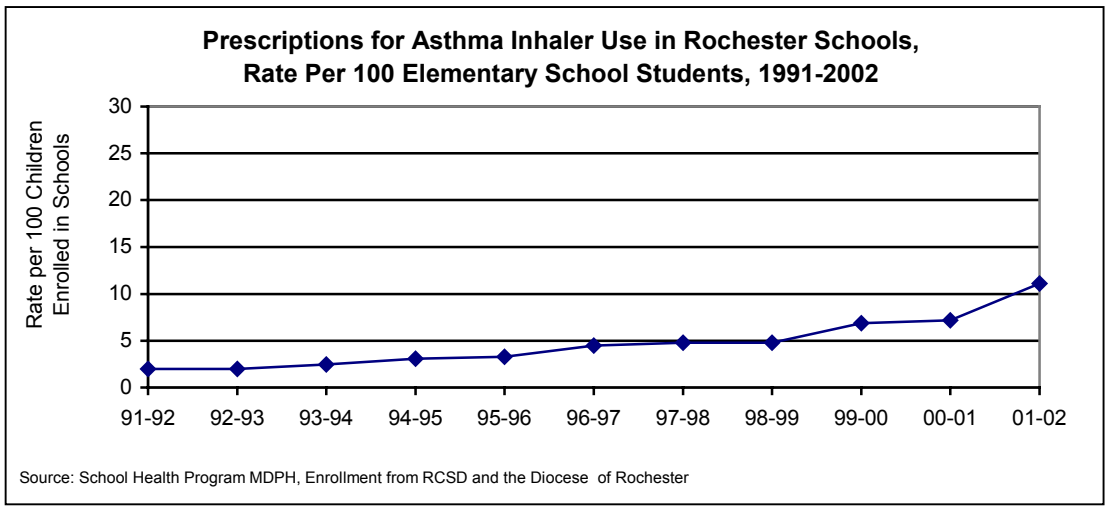
Inhaler Use in Schools, Rochester City Elementary School Students

About the data: This is the number of prescriptions on file with school nurses for inhaler use during school. If the child needs more than one inhaler, there may be more than one prescription per student on file. The source of the data is the School Health Program, of the Monroe County Department of Public Health.

Among Rochester City Elementary School Students:

The number of prescriptions on file with school nurses for inhaler use during school has increased five-fold since the early 1990s, from 437 in 1991 to 2,097 in 2002.

The ratio of inhaler prescriptions to student enrollment increased from 1 out of every 50 students to 1 out of every 10 students. This increase is most likely due to an increase in prescribing of daily preventive inhalers for asthma management.



Appropriate Asthma Medication, Children Enrolled in Managed Care

About the data: This is the percentage of managed care enrollees with asthma who received appropriate medications to control their condition. The medications include inhaled corticosteroids, cromolyn sodium and nedocromil, leukotriene modifiers, or methylxanthines. The source is the New York State Managed Care Performance Report.

Among Children With Persistent Asthma who were Enrolled in Managed Care Programs in the Rochester Region in 2002:

About two-thirds received appropriate medications to control their condition. Rates varied by insurance program.

Children with Persistent Asthma
Who Received Appropriate Medications to Control Their Condition
Children Enrolled in Managed Care Programs in the Rochester Region,
Compared to the Statewide Average ( ), 2002

Blue Choice Commercial (Ages 5-17)	Preferred Care Commercial (Ages 5-17)	Child Health Plus (Ages 5-18)	Blue Choice Option Medicaid (Ages 5-17)	Preferred Care Medicaid (Ages 5-17)
72%▲▲ (65%)	64% (65%)	74%▲▲ (63%)	59% (58%)	65% ▲ (58%)

Source: 2002 New York State Managed Care Plan Performance, NYSDOH.

▲▲=significantly better than the New York State average in 2001 and 2000
▲ =significantly better than the New York State average

Emerging Issues in Asthma Care

During the past decade, there have been substantial advances in the care of children with asthma, the most prevalent chronic disease in children. Improvements have occurred in pharmacologic agents, medical supervision and in service coordination.

Because many children spend several hours a day outside the home, more adults are involved in the supervision and medical care of children with asthma. Recently, greater emphasis has been placed on training and communication about asthma with these important adults in the life of the child. By increasing their knowledge and enhancing their role in the care, signs of exacerbation can be recognized, and treatment can be started earlier. This improves the overall health of the child and prevents absence from school and other activities.

Perhaps the most significant advancement has been the adoption of a more systemic approach to asthma management in children by child health care providers. In the past, many child health care providers provided similar types of care to all children with asthma. Now, the first step in asthma care is determining the level of asthma acuity. Based on this assessment, an individualized asthma care regimen is recommended and closely monitored.

Child health care providers, parents and patients now understand that the pharmacologic agents that are used to treat asthma can be divided into two categories: controller agents and rescue agents. As part of standard practice, child health providers are now recommending "Asthma Care Plans" for children that specify the medications that are used on a routine or regular basis (the controller medications) and those utilized during asthma exacerbation (the rescue medications). This distinction has helped providers, parents, baby sitters, teachers and school nurses to better jointly participate in aspects of care for the individual child.

Several new pharmacologic agents have been developed and the use and delivery of agents have been improved. New delivery systems have been developed that allow children to use the inhaled medications more freely and independently. In addition, preparations and treatment regimens of corticosteroids have been improved so that these agents can be used safely by all children with asthma.

Community Programs to Minimize the Impact of Asthma

Rochester Community Asthma Network

The Rochester Community Asthma Network (RCAN), an affiliate of the local chapter of the American Lung Association is a collaborative that helps promote quality asthma care for children in the counties in the Finger Lakes Region. RCAN has been very active in determining asthma prevalence estimates, developing school measures of asthma control, and outreach and education to families and professionals. The work of RCAN has been supported by grants from NYSDOH and the Aetna Foundation.[18]

[18] For more information, contact alajl@rochester.rr.com

Improve Nutrition and Increase Physical Activity

The Importance of Improving Nutrition and Increasing Physical Activity

Proper nutrition and adequate physical activity are important for maintaining the health of children. Food insecurity, obesity and physical inactivity are three problems that are prevalent in the community.

Food insecurity exists whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain. Lack of food security can cause health problems, lack of energy, and problems with attention, concentration, learning and behavior.[19] Participation in various food programs can improve access to nutritious foods. School breakfast participation has been shown to improve testing scores among students.[20]

The prevalence of obesity is increasing across the nation. Obese children suffer from health and psychosocial complications and are at increased risk of becoming obese adults. The reasons for the increase in the rates of childhood obesity are not entirely clear. Several factors have been suggested as causes, including trends in eating away from home, increased consumption of soft drinks and high fat, high sugar snacks, and food insecurity and lack of access to healthy well-balanced meals. Additional causes include a decrease in physical activity and an increase in sedentary activities like watching TV, playing video games and using the computer.

Measures of Nutrition and Physical Activity

Food Insecurity Among Those Receiving Emergency Food

About the data: This data comes from a survey of clients with children who receive emergency food from providers in the ten-county Rochester Region. The source is America's Second Harvest. "Hunger in America 2001-Local Report Prepared in Conjunction with FOODLINK, Inc.," October, 2001. There were 405 people from the region included in this survey. These percentages do not represent the prevalence of food insecurity in Monroe County. They are an estimate of the prevalence of food insecurity among children from families who access emergency food providers.

Among Clients with Children Who Received Emergency Food in the ten-County Rochester Region:

- 1.5% stated that, during the previous 12 months, their children were *often* not eating enough because they couldn't afford enough food. Another 14.0% of the clients experienced such a situation *sometimes* during the previous 12 months.
- 8.0% said that their children skipped meals because there was not enough money for food during the previous 12 months.
- 10.8% said that their children were hungry at least once during the previous 12 months, but they could not afford more food.

[19] Second Harvest, Differences In Nutrient Adequacy Among Poor And Non-Poor Children, http://www.secondharvest.org/childhunger/child_nutrition.html September 15, 2003

[20] "School Breakfast Programs Energizing the Classroom." Minnesota Department of Children and Families Learning. Roseville, MN, 1998.

Emergency Meals Served to Children in Monroe County

About the Data: This is the number of emergency meals served to children under age 18 in Monroe County during the fiscal year (July-June). Included in the count are meals served in food pantries, soup kitchens and shelters. A child may receive more than one meal per day. The source is FOODLINK.

In Monroe County:

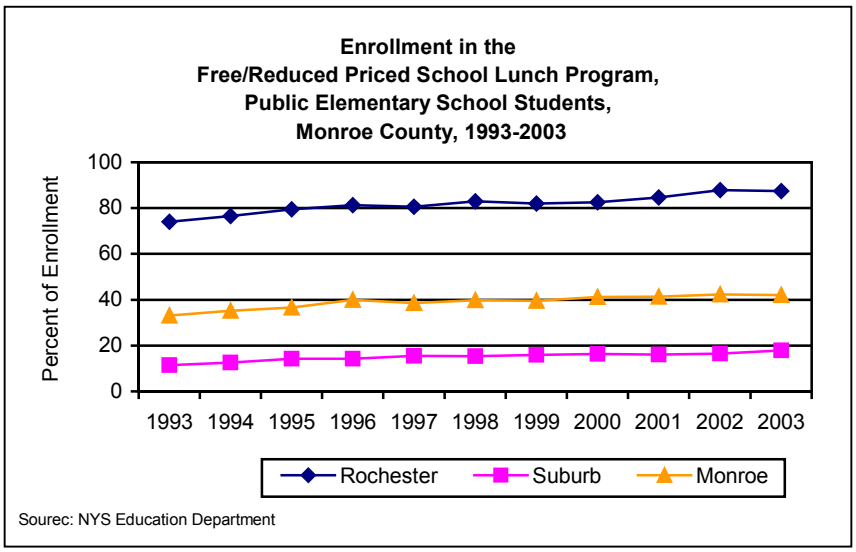
226,027 meals were served to children at food pantries, soup kitchens and shelters during the fiscal year July 2002-June 2003. Based on this number, an estimated 620 emergency meals are served to children each day in Monroe County. The number of meals served increased by 3% since the fiscal year July 2000 to June 2001.

Eligibility and Participation in the Free and Reduced Price School Meals Program

About the data: This is the percent of elementary school students who are eligible for the free and reduced school meals program and the participation rate for entire school meals program (free/reduced/paid). Children are eligible for the free and reduced priced school meal program if their family's income is at or below 185% of the poverty level and they apply through their school district. Families receiving Temporary Assistance or Food Stamps can certify for this program directly. This data is compiled in January of each year. The source is the Child Nutrition Reimbursement Unit of the New York State Education Department.

In Monroe County:

The percentage of students eligible for the free and reduced priced school meals program increased between 1993 and 2003. In January of 2003, 88% (about 16,500) of Rochester City elementary school students and 18% (about 6,400) of suburban elementary school students were eligible for this program.



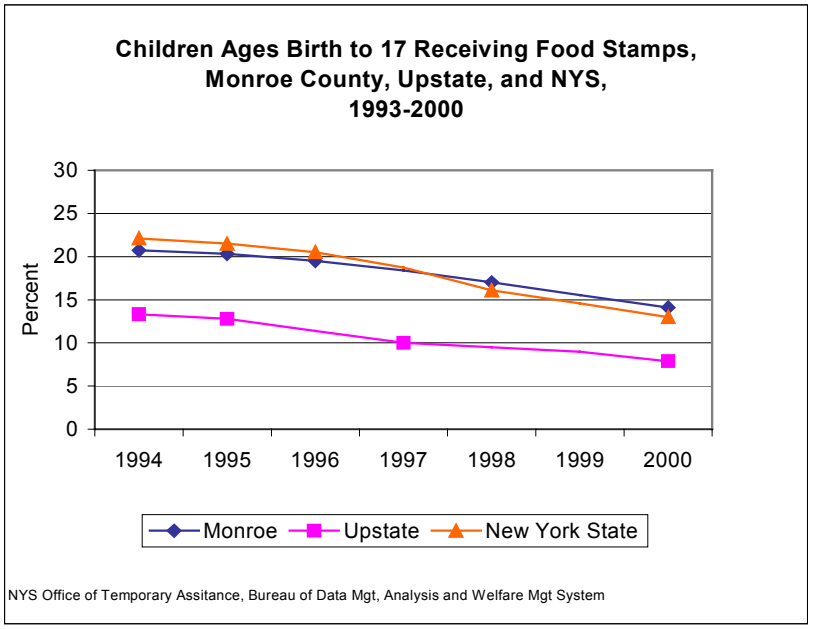
School breakfast is offered in all city public elementary schools. On average each day, only 41% of city elementary students eat school breakfast, compared to 79% who consume a school lunch. Seventy-one percent of suburban elementary schools offer the school breakfast program. On average each day though, only 7% of all suburban elementary school students participate in the school breakfast program compared to 50% who participate in the lunch program. Because not all schools offer the breakfast program, there are about 900 suburban elementary school students who are eligible for the free and reduced priced program but can't participate because it is not offered at their school.

Participation in the Food Stamp Program

About the Data: This is the number and percent of children under age 18 who reside in a household that receives Food Stamps. Low-income households receive Food Stamps in the form of an electronic benefit card that can be used at grocery stores to purchase food. The source of this data is the NYS Office of Temporary Assistance, Bureau of Data Management, Analysis and Welfare Management System.

In Monroe County:

In 2000, 14% (26,482) of children under age 18 received Food Stamps. The number and rate of children receiving Food Stamps declined between 1993 and 2000. The decline was also seen in Upstate and New York State and was in part the result of a thriving economy. Another factor that contributed to the decline was confusion over eligibility guidelines that occurred during the implementation of welfare reform. According to a study by the Urban Institute, a large proportion of US families that left the Food Stamp program in the late 1990s were still eligible for benefits.[21]



Data on Food Stamp participation among Monroe County children for more recent years are not currently available. Extrapolation of existing data, however, strongly support an increase in participation. For example participation in the Food Stamp Program among those of all ages in Monroe County increased by 20% between 2000 and 2003. It is assumed that there was also an increase in the number of children participating in this program during this same time period.

As shown in the graphic above, the percentage of children receiving Food Stamps in Monroe County is higher than Upstate and New York State. This may stem from the fact that Monroe County has a higher proportion of eligibles participating in the program. A recent analysis completed by Office of Temporary and Disability Assistance shows that in Monroe County the proportion of Food Stamps participants to the number of people living in poverty is 77%.[22] This proportion ranks first out of all New York State counties. Despite ranking high, there is still almost a quarter (23%) of people who are eligible for Food Stamps in Monroe County who are not receiving benefits.

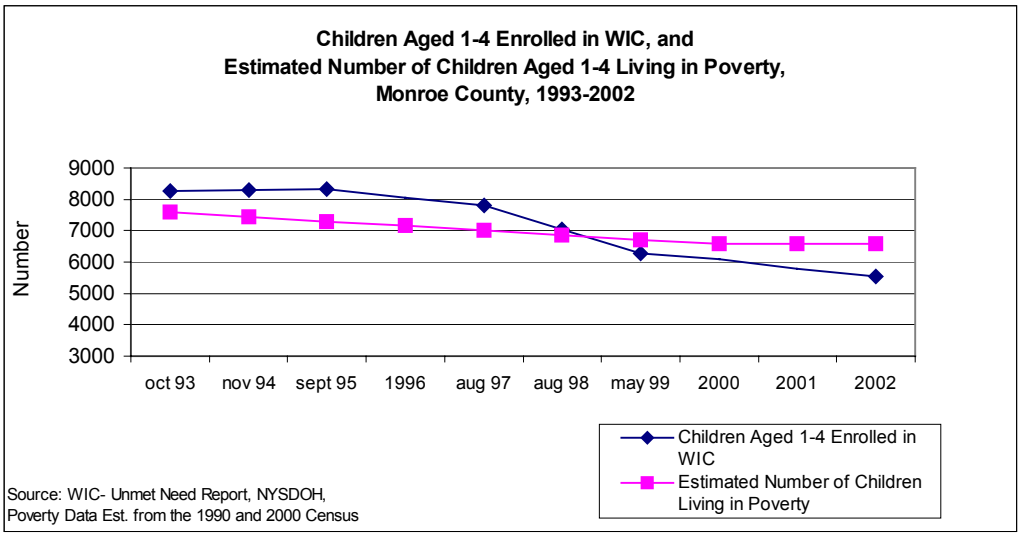
[21] Food Stamp Program. Washington, D.C.: The Urban Institute. Assessing the New Federalism Discussion Paper 01-05.
[22] According to Census 2000.

Enrollment in the WIC Program (Women Infants and Children Program)

About the Data: This is the number of children aged 1-4 years old enrolled in WIC. The WIC Program provides nutrition education and checks to be used to purchase selected nutritious foods. Eligibility for WIC is 185% of the poverty level. Data were not available for 1996, 2000 and 2001. The source is the New York State Health Department.

In Monroe County:

Since 1993, the number of children aged 1-4 enrolled in the WIC program has declined by 33%. The graphic below shows the number of children enrolled in WIC compared to the estimated number of Monroe County children aged 1-4 living in poverty. Since WIC serves children aged 1-4 living at 185% of the poverty level, theoretically, all children living in poverty should be eligible for WIC. The graphic shows that in 2002, there were fewer children enrolled in WIC compared to the estimated number of children aged 1-4 living in poverty.



One of the major factors contributing to the decline in WIC participation among children is an increase in the proportion of women working outside of the home. Because of this, a greater proportion of children are now eating at least some of their meals in day care, thus reducing the need and/or perceived need for WIC supplemental food at home. In addition, women who are working have limited availability to attend WIC sites. To address the availability issue, some WIC programs serving Monroe County residents have been offering evening and Saturday WIC clinics.

Focus groups conducted by the Division of Public Health Practice of the University of Rochester for the Monroe County Health Department WIC Program in 2000 revealed additional reasons for the drop-off in enrollment. They include confusion over whether or not children are eligible for WIC after age one, and the perception that the value of WIC foods received every month is not worth the required paperwork and the time needed to attend WIC appointments.

As noted on page 30, it is thought though that a majority of infants eligible for WIC are participating in the program.

Child and Adult Care Feeding Program (CACFP)

About the Data: This is the average daily attendance for licensed daycare centers and family day care providers that participate in the Child and Adult Care Feeding Program. This program provides reimbursement to care providers for serving nutritious meals to children under age 12. The source of these data is the New York State Health Department.

In Monroe County:

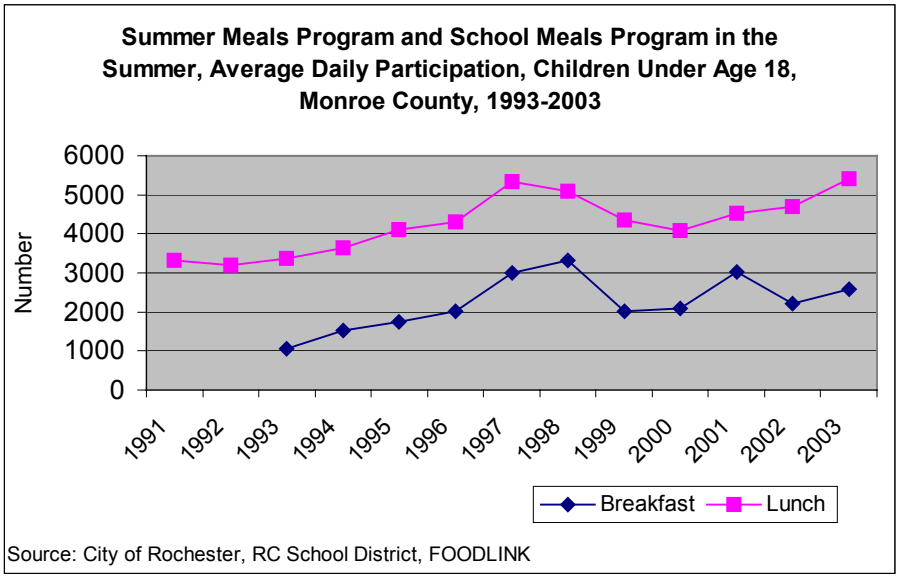
On average each day during 2002, more than 12,000 children attended day care centers or family day care providers in which nutritious USDA approved meals were served. This number increased by 8% since 2000.

Participation in Meal Programs During the Summer

About the data: This is the number of children under age 18 who receive meals during the summer at more than 80 sites in Monroe County, most of which are in are in the City of Rochester. These figures were calculated by adding the average daily participation (ADP) of the Summer Foodservice (SFS) program operated by the City of Rochester, the ADP of the FOODLINK SFS program and the ADP of school meals served at City Schools during July and August. Note that data for these programs are not available by age group so they contain data for all children under age 18. The sources of the data are the City of Rochester, the Rochester City School District and FOODLINK. Participation data from three other smaller summer meals programs in the county are not included here.

In Monroe County:

On average each day during the summer of 2003, about 5,400 children received a lunch and about 2,600 received a breakfast from these programs. As shown in the chart to the right, participation is increasing.



Despite this increase in Monroe County, the program only reaches a small percentage of low-income children (12%).[23]

[23] Hunger Data Book 2002, Nutrition Consortium of New York State. http://www.Hungernys.org/programs/publications/hdb/profiles/page62.html

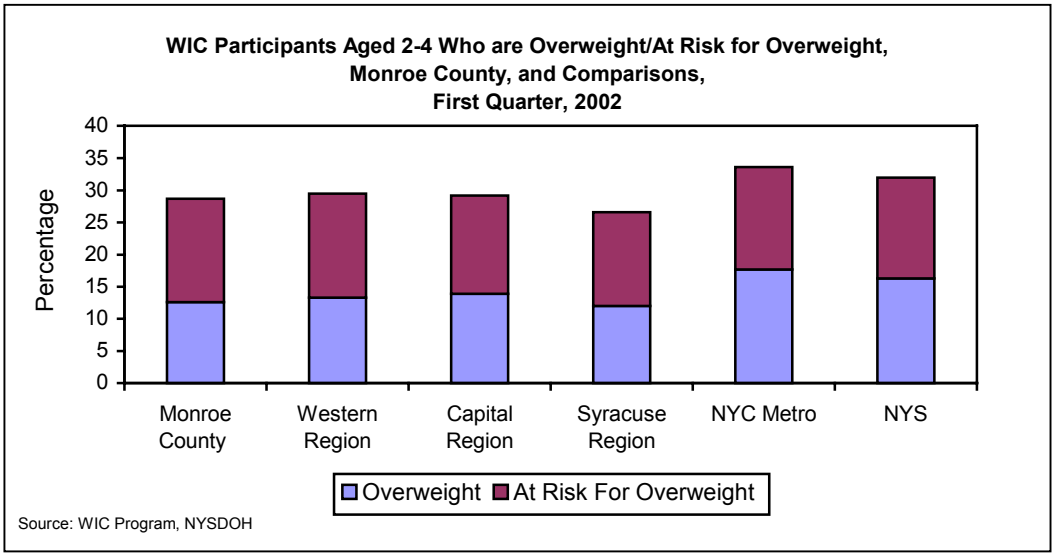
Overweight Prevalence, WIC Participants age 2-4 years old.

About the data: These data include participants enrolled in WIC during the first quarter of 2002 at any site within Monroe County. Overweight in children is defined as a BMI-for-age at or above the 95th percentile on the 2000 CDC growth charts. At risk for overweight is defined as a BMI-for-age at or above the 85th percentile but below the 95th percentile. The source of these data is the WIC Program of the New York State Department of Health.

In Monroe County:

- 12.6% of children aged 2-4 years old enrolled in WIC are overweight and another 16.1% are at risk for being overweight.

- The proportion of children enrolled in WIC who are overweight or at risk for being overweight is similar to the proportions in all of New York regions except New York City.



Overweight Prevalence, Children Aged 19-24 Months in Monroe County

About the Data: This is the estimated percentage of children aged 19 and 24 months who are overweight. Overweight is defined here as greater than or equal to the age specific 95th percentile on the 2000 CDC weight for height growth charts. The source of the data is the 2002 Immunization and Primary Care Survey.

In Monroe County:

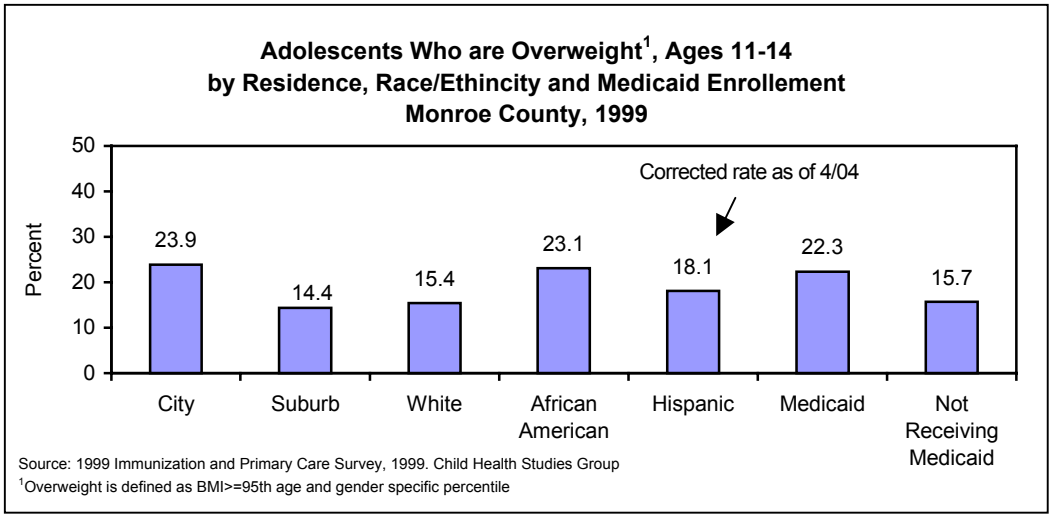
- 9.3 % of children aged 19-24 months are overweight.

Overweight Prevalence, Children Aged 11-14

About the data: Currently there is no data source on the prevalence of overweight among elementary school aged children. Although the data shown below are about young teens, they provide some indication of the problem of overweight among school aged children. Overweight in children is defined as a BMI-for-age at or above the 95th percentile on the 2000 CDC growth charts. At risk for overweight is defined as a BMI-for-age at or above the 85th percentile but below the 95th percentile. The source of the data is the 1999 Immunization and Primary Care Survey.

In Monroe County:

17% of children aged 11-14 years are overweight and another 17.2% are at risk for being overweight. As shown in the chart below the rate of overweight is higher in the city compared to the suburbs, among minorities compared to Whites and among those enrolled in Medicaid, compared to those not enrolled in Medicaid.



Behaviors That Influence a Child's Physical Activity and Nutrition- Children Entering Rochester City Schools

About the data: The source of these data is the PACE Survey, 2001-2002, compiled by Children's Institute.

Parents Surveyed Reported the Following About their Children's TV Viewing, and Eating Patterns:

- 72% watch 2-4 hours of television daily, and another 8% watch 5 or more hours per day.
- 13% do not always eat breakfast.
- Only 66% eat together with their family daily, 18% reported four to six times per week and 16% reported 1-3 per week.

Emerging Issues Related to Nutrition and Physical Activity

Emerging Epidemic

During the past three years, the problem of obesity has come into focus as a critical public health problem. The increasing weight of Americans is a problem for children, adolescents and adults. Addressing this problem and reversing this alarming trend will not occur through a simple program or service. It will require a concerted effort, targeting differing populations utilizing integrated interventions. For a problem this large and complex, it is clear that the solutions and the resources will have to come from the national or state level. However, there is great promise for local communities to work in a collaborative fashion across sectors to drive down the rate of obesity.

Scientific Basis for Obesity Prevention and Intervention

Although the problem of obesity is not new, the science-base for obesity prevention and intervention at the population level is still relatively weak. Lack of physical activity and excessive caloric intake are well defined as the behavioral risk factors. But surprisingly very few interventions exist that have evidence of effectiveness to address obesity at the population level.

The absence of evidence-based interventions poses a great dilemma for communities. Pure scientists maintain that substantial efforts should be put into research to find out what works and what doesn't work and what might actually make things worse. Action-oriented leaders suggest rushing ahead with interventions that make sense or have partial evidence of effectiveness. They reason that the problem is so serious that inaction is indefensible.

In August 2003, the American Academy of Pediatrics released a Policy Statement on Prevention of Pediatric Overweight and Obesity. The report contains recommendations for child health care providers pertaining to health supervision and advocacy. In 2001, the CDC's Task Force on Community Preventive Services published a report that examined the science base for interventions to promote physical activity. The task force found evidence to support the following interventions.[24]

- Community-wide social marketing campaigns to promote physical activity
- Point of decision prompts to encourage use of stairs
- Individually adapted health behavior change programs
- School-based physical education programs
- Social support interventions in community settings

The science base for obesity prevention through promoting good nutrition is even sparser. There is good evidence that promoting breast-feeding can reduce the risk of obesity later in life. The CDC's Task Force on Community Preventive Services plans to release a series of reviews of studies regarding population-based nutritional interventions in 2004.

[24] see www.cdc.gov/mmwr/preview/mmwrhtml/rr5018a1.htm

Type II Diabetes and Metabolic Syndrome

The general public seems to have the impression that all obesity is the same except for the degree of obesity. In fact, at the individual level, there is tremendous genetic, familial and metabolic variability among obese persons. The epidemic of obesity has greatly increased the prevalence of Type II diabetes in children. Until recently, Type II diabetes was synonymous with adult-onset diabetes. Now obese children and adolescents are screened for glucose intolerance and are receiving many of the same treatment approaches as adults.

Recently, another syndrome, the metabolic syndrome has been identified as a subset of obese individuals that have measurable metabolic abnormalities (hypertension, dyslipidemia, glucose intolerance and central obesity). It is estimated that approximately 22% of the adult population and about 4% of the childhood population in the United States have the metabolic syndrome.

This is significant because, behavioral lifestyle programs and some medications are of benefit in preventing diabetes in adults. We know this syndrome greatly elevates the risk for adult type diabetes and premature coronary artery disease. Unfortunately, no specific guidelines exist yet for the treatment of metabolic syndrome in children.

Community Programs to Improve Nutrition and Increase Physical Activity

There are numerous programs in our community that address the problems of improving nutrition in children and increasing physical activity but even with the presence of these programs, childhood obesity appears to be worsening locally. Many current programs are being adapted to place more focus on obesity prevention and some new programs have been developed.

For example, the NYS WIC program has formally adopted the Eat Well Play Hard Campaign. These materials are routinely distributed to WIC clients. One percent milk is now the "default" on WIC checks for children ages 1-4 years of age. Cornell Cooperative Extension provides nutrition education classes to parents and children including Food Stamp recipients and Summer Meals Program participants. FOODLINK has developed a nutrition education curricula designed for use in grades K-2 and 3-5. NYSDOH promotes the "Just Say Yes to Fruits and Vegetables Program" among emergency food providers. Local school districts have revised their school meal menus to reduce fat content of the meals and offer healthy a la carte items.

Under the banner of Project Believe, the University of Rochester Medical Center has provided leadership in the development of new programs related to obesity prevention and intervention in children. The Rochester Urban Nutrition and Fitness Initiative is a program that assists city pediatric offices by offering a nutrition-physical activity program for families at the YMCA. The Creating Opportunities for Personal/Parent Empowerment (COPE) Program has been designed to prevent inner city children who are obese or at risk for obesity from developing Type II diabetes.

The Rochester Urban Fitness Challenge is a collaborative effort between the University of Rochester Medical Center and the Rochester City School District to purchase updated equipment for Rochester middle and high schools to promote physical activity within the district's physical education program.

The Nutrition Education and Outreach Project of the YWCA works to decrease the amount of food insecurity in the community by providing information and education about various food and nutrition programs available for children. In addition to distributing food to emergency food providers, FOODLINK runs 24 Kids Café Programs after school. These programs provide both nutrition education and nutritious meals and snacks to low income children.

Recently, the YMCA of Greater Rochester has partnered with the Rochester Primary Care Network to provide physical education and health promotion at 10 after school child care sites in Monroe County. The YMCA will utilize the Coordinated Approach to Child Health Program (CATCH), which was funded by the National Heart Lung and Blood Institute and has been shown to be effective in reducing fat intake and increasing self-reported physical activity among participants. CATCH after school activities will include two related components: indoor and outdoor physical activity; and classroom-based learning activities. These components will be split into two separate grade levels: K-2 and 3-6. The goals of the program are to engage all children in a minimum of 30 minutes per day of enjoyable moderate to vigorous physical activity and to equip children with the knowledge, skills, self-efficacy and intentions to make health physical activity decisions. This program is slated to begin in January 2004.

Reduce Exposure to Lead

The Importance of Reducing Lead Exposure

Lead poisoning affects nearly every system in the body, including the kidneys, bone marrow, reproductive system and the central nervous system. Lead can damage a child's developing brain and nervous system, which can cause behavior, attention, learning and coordination problems. Decreased stature and slower growth, along with impaired hearing can also be the result of lead poisoning. Recent studies have shown that even low lead levels can adversely affect a child's intelligence, behavior and development.

Measures of Reducing Exposure to Lead

Screening for Lead Poisoning

This is discussed under Improving Access to Preventive Health Services. See page 47.

Incidence of Lead Poisoning (>=20μg/dl), Among Children Screened

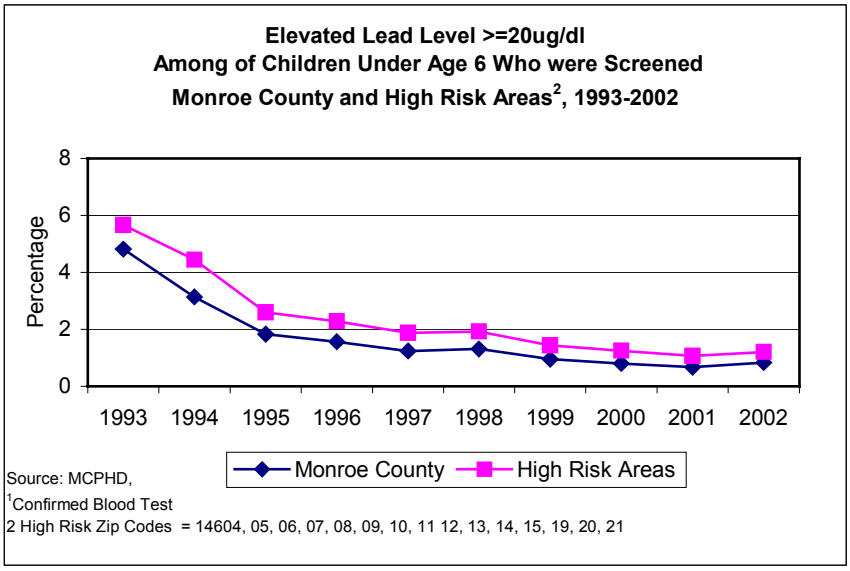
About the Data: The following data show the number and percent of children screened for lead poisoning who had a confirmed (venous) elevated lead level >=20μg/dl. Any child with an elevated lead level (>=20μg/dl) is required to receive an elevated blood lead (EBL) investigation to identify the source of the lead and then to develop a plan to minimize exposure. In response to recommendations of the NYSDOH and CDC, the Monroe County Department of Public Health presented a protocol to the Monroe County Legislature to lower the environmental blood lead investigation level. A local law was passed and filed with NYS on August 25, 2003 and the new protocol began on October 1, 2003. This law allows for an environmental blood lead investigation when a child has two venous blood levels that are between 15-19 μg/dl within one year and a minimum of 3 months apart. Prior to October 1, 2003, environmental blood lead investigation was conducted at the mandated level of >=20μg/dl. Thus data from previous years only have confirmed levels for >=20μg/dl. The source is the Monroe County Department of Public Health.

In Monroe County:

In 2002, 112 children under age 6 had a confirmed blood lead level of >=20μg/dl. Most (104) resided in high-risk zip codes in the city of Rochester. In 2002, the rate of elevated lead levels (>=20μg/dl) among those screened was 0.83% in Monroe County as a whole and 1.20% in high-risk zip codes.

Between 1993 and 2001 the rate declined in both Monroe County and high-risk areas. In 2002, the rate increased but not significantly. It is thought that the decline in the number of children with elevated lead levels may be due in part to decreased screening in high-risk areas.

The decline in rates also occurred in New York State between 1993 and 1999. Data from 2000 and 2001 from New York State are currently not available.



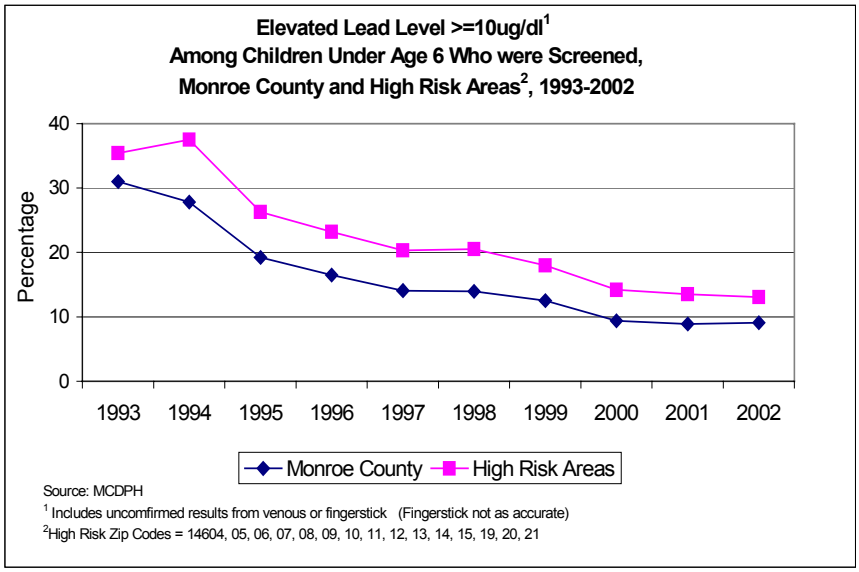
Incidence of Lead Poisoning, (>=10μg/dl), Among Children Screened

About the Data: The following data show the number and percentage of children screened who had a lead level >=10μg/dl. The data include children who were screened using a finger-stick or venous sample. Because of the unreliability of finger-stick testing, this data is presented only as an estimate of the number of children with levels >=10μg/dl. The source is the Monroe County Department of Public Health.

In Monroe County in 2002:

1,234 children had a lead level at or above 10μg/dl. The rate is significantly higher in zip codes within the City of Rochester (13.1%) compared to the County as a whole (9.1%).

Since 1993, the rate and number of children testing at this level has declined significantly in high risk city zip codes and county wide. It is thought that the decline may be due in part to decreased screening in high-risk areas.



Emerging Issues in Lead Poisoning

In the past few years there has been resurgence in interest in combating the problem of lead poisoning in America and in Rochester. This activity was sparked by a challenge issued in 1998 by the federal Department of Housing and Urban Development (HUD) to eliminate lead poisoning in America by the year 2010. This challenge was accompanied by changes in HUD funding guidelines that require communities to prioritize lead hazard reduction in their housing improvement activities.

Public health planners around the country have recognized that the elimination of lead poisoning can only occur if communities recognize that lead poisoning is a housing problem (not just a child health problem) and that a preventive approach is necessary.

Most public health agencies utilize their resources to require lead hazard control of properties that contain lead paint hazards where a child with an elevated blood lead level resides or spends considerable time. This current approach is being reassessed and new emphasis is being placed on the primary prevention approach that seeks to identify properties that contain lead hazards prior to the child developing an elevated lead level. The federal government and some state health departments are developing similar primary prevention protocols.

Over the past 30 years, the Centers for Disease Control has lowered the blood lead level of concern from 40μg/dl to the current level of 10ug/dl which was set in 1991. The CDC set the blood lead level at 10μg/dl because research at the time had shown the metal to have a negative health effect above this threshold. In 2003, a study published in the New England Journal of Medicine and carried out by Cornell University, Cincinnati Children's Hospital and the University of Rochester School of Medicine suggests lead may be harmful at levels below 10μg/dl.[25] This study has provoked a controversy about further lowering the cut-off. It's unlikely one study will be the basis for lowering the acceptable lead level but it may encourage further research on how low lead levels affect children.

In the past two to three years, plantiffs' attorneys have begun a campaign to bring suits against landlords and local governments related to lead poisoning.

Community Programs to Reduce Exposure to Lead

The Coalition to Prevent Childhood Lead Poisoning

In 2000 the Coalition to Prevent Childhood Lead Poisoning was formed to help coordinate and spark community activities to promote lead poisoning prevention in children. The coalition has obtained several grants from local foundations to support staff and pilot projects. The coalition has released a list of actions that they suggest each level of government should take to enhance their prevention efforts.

The coalition has also developed the Get the Lead Out (GLO) pilot intervention in the neighborhood around School 17. With the leadership of Dr. Richard Kennedy at the Orchard Street Health Center, the coalition has been able to perform lead hazard assessments in a small number of homes of families with children. This pilot may be used to encourage local governments and homeowners to revise current protocols.[26]

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[25] Canfield, Richard, et.al. "Intellectual Impairment in Children with Blood Lead Concentrations below 10ug/dL." New England Journal of Medicine. April 17, 2003. 348:1517-1526.

[26] For more information contact pbrantingham@yahoo.com.

Lead Poisoning Prevention Program, Monroe County Department of Public Health

For many years, the Monroe County Department of Public Health has been providing community leadership in promoting reduction in lead hazards to children and protecting children with lead poisoning. With new community interest in lead poisoning, the program has found new partners in addressing this important community health problem.

On a daily basis, program staff receive lead test results from the New York State Department of Health, review the results and place them in a data base. Lead Program nurses refer venous levels of 10-19μg/dl to community outreach workers that perform educational visits at home and coordinate their efforts with primary care providers.

If the level of lead in a child's blood exceeds 20μg/dl, or if it is between 15-19μg/dl on two successive tests, three months apart, the program's environmental staff conduct an elevated blood lead investigation to find the potential sources of lead exposure. An investigation is conducted at all properties where the child resides or frequently visits. When the source is found, the environmental staff initiate a formal enforcement proceeding to assure that the hazards are cleaned up.

In the past, property owners had very few opportunities to obtain financial assistance in performing lead hazard control. Now, both the City of Rochester and the County of Monroe have programs that offer education and financial support. These programs utilize the HUD guidelines for lead hazard reduction.

The Lead Program contracts with the Rochester Housing Council to teach a "Lead Safe Work Practices Class." During this class, workers and landlords are taught to use lead safe work practices. Monroe County is also involved in providing numerous education sessions to raise awareness about lead poisoning and prevention.[27]

Monroe County HUD Grant

The Monroe County Department of Public Health was awarded a 30-month grant by HUD to fund lead hazard reduction work in City of Rochester properties. This grant allows the health department to fund work in 300 properties in which the owner has received a "Notice and Demand to Abate a Condition of Lead Poisoning." The grant will, in part, fund interim controls, dust and soil remediation as well as owner/worker lead-safe work practices training. Another 120 units will be targeted for extensive remodeling to permanently address lead hazards.[28]

City of Rochester HUD Grants

The City of Rochester has been the recipient of federal housing grants for many years. In 2001, the federal Department of Housing and Urban Development began to require that lead hazard remediation be the top priority in the use of these funds. In 2002, the city announced that 5 million dollars in HUD funds would be made available for projects to reduce lead hazards in owner occupied and rental properties.[29]

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[27] [29]For more information see http://www.monroecounty.gov/org158.asp
[28] For more information, contact rshrader@monroecounty.gov
[29] See http://www.ci.rochester.ny.us/dcd/srvguide/housingprojdev.htm

Reduce Unintentional Injuries

The Importance of Reducing Unintentional Injuries

Most injuries are predictable and preventable, however unintentional injuries remain one of the leading causes of death among children. Most injuries do not result in death, but some are serious enough to cause permanent disability and pain. Nationally it is estimated that for every childhood death caused by injury, there are approximately 34 hospitalizations, 1000 emergency department visits, many more visits to private physicians and school nurses, and an even larger number of injuries treated at home.[30]

Measures of Unintentional Injuries

Deaths Due to Unintentional Injuries

About the Data: The source of this data is the Department of Vital Records of the New York State Health Department.

In Monroe County:

About 7 children under the age of 10 die each year due to unintentional injuries.

The causes of death due to unintentional injuries during 1998 through 2000 are listed below.

Causes of Deaths[1] Due to Unintentional Injuries, Birth to Age 4, Monroe County, 1998-2000	Number
Suffocation	6
Drowning	2
Pedestrian	2
Motor Vehicle Crash	1
Scald	1
Struck by or against	1

Source: Vital Records, MCHD
[1]1998 ICD-9, 1999-00 ICD-10 classifications of injuries, Wa. State Injury Program Groupings.

Causes of Deaths[1] Due to Unintentional Injuries, Ages 5-9, Monroe County, 1998-2000	Number
Pedestrian	2
Fire/Flame	1
Motor Vehicle Crash	1
Bike	1
Fall	1
Struck by or against	1
Unintentional Firearm	1

Source: Vital Records, MCHD
[1]1998 ICD-9, 1999-00 ICD-10 classifications of injuries, Wa. State Injury Program Groupings.

[30] National Center for Injury Prevention and Control, September 15, 2003.) (http://www.cdc.gov/ncipc/factsheets/childh.htm,

Hospitalizations Due to Unintentional Injury

About the data: This is the number of hospital discharges of children with a diagnosis of an unintentional injury. The source of these data is the Statewide Planning and Research Cooperative System (SPARCS) of the New York State Department of Health.

In Monroe County:

In 2002, there were 99 hospitalizations of children aged birth to 4 due to unintentional injury. There were 98 hospitalizations among children aged 5-10. Falls are the leading causes of hospitalizations due to unintentional injuries in both age groups.

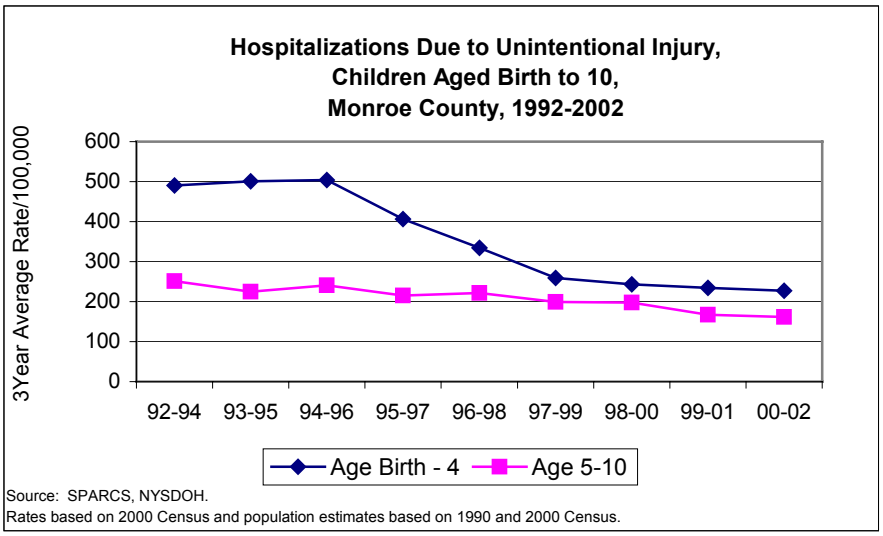
Leading Causes of Hospitalizations Due to Unintentional Injuries, Birth to age 4, Monroe County, 2000-2002	Number
Falls	95
Poisoning[1]	52
Scalds	44
Pedestrian	17
Struck by an Object/person	10

Source: SPARCS, NYSDOH
[1]Includes Lead Poisoning

Leading Causes of Hospitalizations Due to Unintentional Injuries, Age 5-10, Monroe County, 2000-2002	Number
Falls	102
Bicycle	37
Struck by an Object/person	36
Pedestrian	33
MVC	29

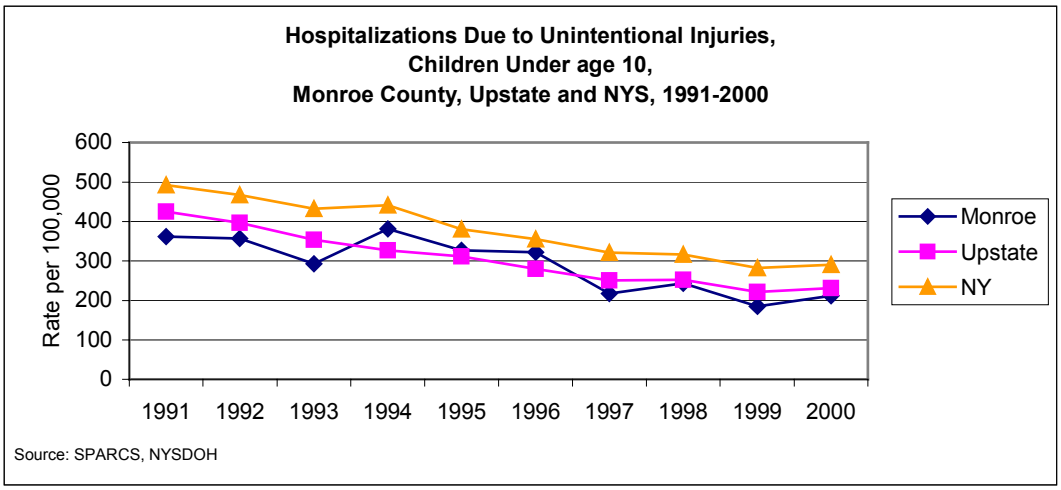
Source: SPARCS, NYSDOH

Since 1992, the rates of hospitalizations due to unintentional injuries declined significantly especially among children under age 5. It should be noted that major reason for the decline is the decrease in hospitalizations due to lead poisoning. Lead poisoning is included in the New York State Health Department's definition of unintentional poisoning injury.



Source: SPARCS, NYSDOH.
Rates based on 2000 Census and population estimates based on 1990 and 2000 Census.

Similar declines were seen in Upstate NY and NYS. The rate in Monroe County is comparable to the rate in Upstate, and lower than the rate in NYS.



Rates of unintentional injury hospitalizations among children age 0-10 years old are about 2-3 times higher among African Americans compared to Whites. Zip code areas with the highest numbers of hospitalizations due to unintentional injury include 14605, 14606, 14608, 1409, 14611, 14621.

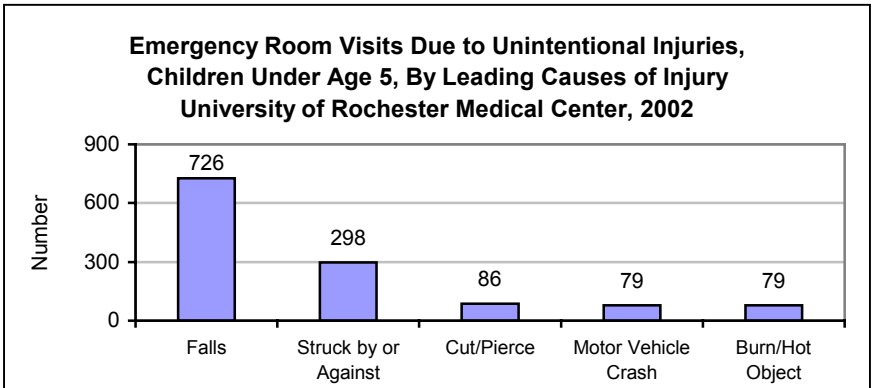
Emergency Room Visits Due to Unintentional Injuries

About the data: When children present to the emergency room with an injury-related diagnosis, an attempt is made to make a determination of the external cause of the injury. This data includes injuries that were unintentional, sometimes called accidents. In some cases, the cause of the injury is not recorded, so it is unknown. These unknown causes are included in the total counts. The source is the Pediatric Emergency Department of the University of Rochester Medical Center

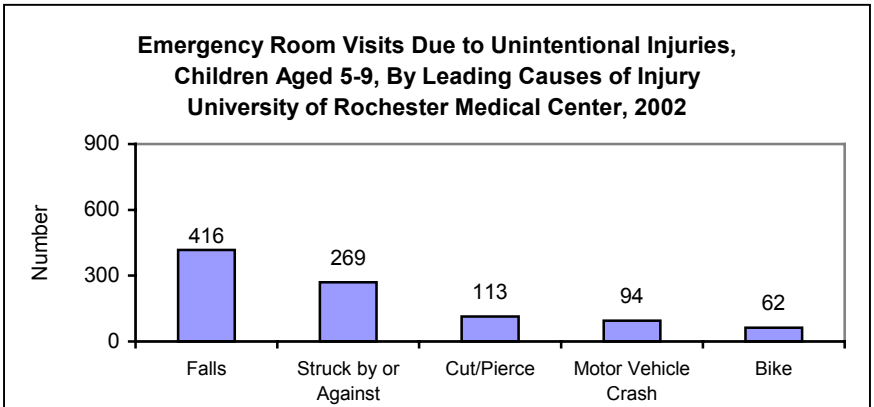
At the University of Rochester Medical Center, During 2002:

There were 3,355 emergency room visits due to unintentional injuries among children under age 5 years old and another 2,285 visits among children aged 5-9 years old.

In both age groups, falls were the leading cause of emergency room visits due to injury. Motor vehicle crashes however, tend to be the most serious type of injury, often resulting in hospitalization.



Source: University of Rochester Medical Center,
CDC recommended framework of Ecode groupings for presenting injury data



Source: University of Rochester Medical Center,
CDC recommended framework of Ecode groupings for presenting injury data

City of Rochester zip codes with the highest number of emergency room visits due to injury among children under age 18 include: 14605, 14608, 14609, 14611, 14612, 14619, 14621. (Note that these include both unintentional, and intentional.)

Injury Prevalence -Children Entering Rochester City Schools

About the data: The source of these data is the PACE Survey from the 2001-2002 school year, compiled by Children's Institute.

Parents Surveyed Reported the Following About their Children's Health:

- 33% ever had one or more accidents or injuries that required medical attention.

Emerging Issues Related to Unintentional Injuries

Unintentional injuries remain one of the most common causes for children to visit emergency rooms and be admitted to hospitals. Recently, hospitals have developed better data systems that allow for better determination of causes and trends in these injuries. It is becoming standard practice for hospital emergency departments to use "e-codes" for classifying injuries.

The development of Geographic Information Systems for analysis of distributions is a new tool available for communities to use in determining the distribution of injuries in the community and for tracking the impact of interventions. For example, these systems can alert transportation planners about the most dangerous highways or intersections for motor vehicle, pedestrian and bicycle injuries so that traffic safety improvements can be made.

Community Programs to Reduce Unintentional Injuries

In 2003, the Department of Emergency Medicine at the University of Rochester was awarded a grant by The Robert Wood Johnson foundation to establish the Injury Free Coalition of Rochester. The coalition will work with health care providers and injury prevention programs throughout Western New York to promote evidence-based strategies to reduce the incidence of child injury and to improve injury care for children.[31]

[31] For more information contact Lynn_Cimpello@urmc.rochester.edu.

Improve Social and Emotional Well Being

Social and Emotional Well Being in Children: An Opportunity for Prevention

The 2003 Monroe County Child Health Report Card contains a new goal titled "Improve Social and Emotional Well Being". The inclusion of this new goal recognizes that "child health requires more than physical health". It seems logical that a community would want to improve the social and emotional well being as well as to improve the physical health of its children.

The term "social and emotional well being" may not be familiar to health-care workers. However, it is used widely among educators and psychologists. In reference to adults, instead of using the term social and emotional well being, health-care workers use such terms as wellness, mental health or behavioral health. However, these terms are generally not applied to children, except in the treatment domain.

Some may think the "social and emotional well-being" has a non-scientific ring to it, but in fact there is a body of knowledge in which social and emotional well being is measured and studied. There is no generally accepted simple definition of social and emotional well being. In fact, social well being and emotional well being are overlapping constructs.

In layman's terms, social well being exists when people live with each other successfully or when their interactions facilitate cooperation, understanding and promote human dignity. Emotional well being exists when people recognize their feelings, understand how their feelings affect their functioning and are able to deal with them successfully.

In more scientific terms, *pro-social indicators* include feeling attached to and part of a family, making and maintaining friends or establishing and maintaining working relationships with peers. *Antisocial indicators* include weak or absent family relationships, isolation, fighting or inability to initiate or maintain relationships. Since social well being involves others, it generally can be observed directly and fairly objectively.

Indicators of *emotional well being* include feeling happy and optimistic, and experiencing competence when faced with challenges. Indicators of the *lack of emotional wellbeing include* feeling anxious, sad, or depressed for extended periods of time, or experiencing extreme mood swings. Since emotional well being is primarily an internal state, it is harder to measure objectively. Its presence is either based on self-report or inferred by observation.

The Importance of Improving Social and Emotional Well Being

Social and emotional well being in children is considered an important factor that protects the individual from harm during life's challenges. Early well being is statistically associated with well being and success in the future. Social problems and emotional problems in children predict later functional difficulties in school failure; substance abuse; mental health problems and involvement in the criminal justice system. The specific area that will be affected is undifferentiated until adolescence or adulthood.

Measuring social and emotional well being early is important because its absence portends problems in the future. The social and emotional well being construct fits nicely with a public health prevention framework. For this reason, measures of social and emotional well being are included in this report card.

Measures of Social and Emotional Well Being

Behavioral Problems, Children Entering Rochester City Schools

About the data: The source of these data is the PACE Survey from the 2001-2002 school year, compiled by Children's Institute.

Parents Surveyed Reported the Following About their Children's Behavior:

- 8% need extra help with their behavior
- 22% 'maybe' need extra help.

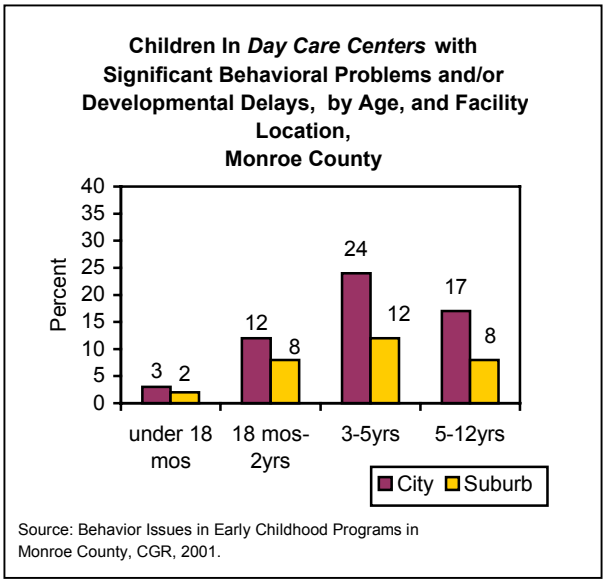
Severe Behavior Problems and/or Developmental Delays in Day Care Programs

About the data: The Center for Governmental Research conducted a study to quantify the number and percentages of children attending formal child care who in the providers' judgement have severe behavior problems, developmental delays and/or disabilities that are disruptive to child care program activities. Severe behavior problems include being overly aggressive, defiant, hyperactive, or withdrawn. Developmental disabilities include delays in listening, talking, learning, self-help skills and coordination.

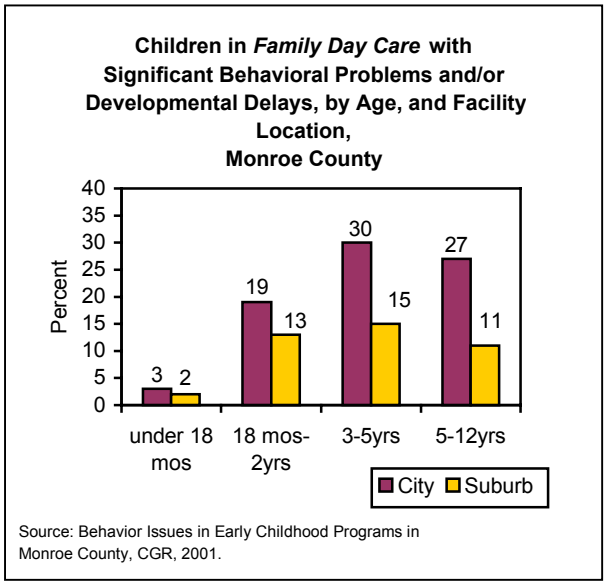
Day care centers and licensed family day care providers were included in the study. Informal providers, Rochester City School District preschool programs and specialized programs for children with specific developmental disabilities were not included.

In Monroe County:

An estimated 16% (3,600) of children aged 12 years and under in child-care exhibit at least one of these behavior and/or developmental problems. The prevalence rate is higher in city based child care settings (20%), compared to suburban based child care settings (10%). As shown in the graphics below the prevalence is highest among children aged 3-5 years old who attend care in the City of Rochester.



Source: Behavior Issues in Early Childhood Programs in Monroe County, CGR, 2001.



Source: Behavior Issues in Early Childhood Programs in Monroe County, CGR, 2001.

Ninety percent of child-care center providers and two-thirds of family day care providers reported that, at any given time, they have at least one child enrolled in their program that displays one or more of these problems. In addition, the providers report that more than half of these children do not receive all of the support services needed.

Severe Behavior Problems and/or Developmental Delays in City Preschool Programs

About the data: During the 2001-2002 school year, the Rochester City School District assessed about 1,100 three and four year old children attending their preschool program. A Standardized Teacher Rating Scale was used as a measure of four areas: behavior control; assertive social skills; peer sociability and task orientation. The source of the data is the report "Behavior Issues in Early Childhood Programs," CGR, October 2001.

In the City of Rochester Preschool Program:

- Approximately 30% (339) children had one or more social/emotional problems in the four areas listed above.

School Adjustment Problems – Monroe County School Children, Grades K-3rd

About the data: The AML-R developed by the Children's Institute is a brief screening tool used by primary school teachers in Monroe County to help them identify children experiencing school adjustment problems. The tool contains 12 questions that rate whether the child exhibits the following behaviors: 1. Acting out/disruptive, 2. Moody/shy/withdrawn, 3. Learning problems. Teachers observe students and rate them by how frequently they observe the various behaviors. Scores for each child are then compared to normative scores for New York State children with similar age, gender and area of residence (urban vs. non-urban). Children who score at or below the 15th percentile for their age group, within any of these areas, are considered at risk for school adjustment problems.

In Monroe County:

Nearly 32% of K-3 students scored at or below the 15th percentile for one or more AML-R areas, making them at risk for school adjustment problems. The table below shows the percentages of Monroe County school children with one or more of these problems. The percentage of children at risk, increased significantly during the three years in which data was collected. The rate in the city (35%) is significantly higher than the rate in the suburbs (29%).

Percent of Monroe County Primary School Children, at Risk for School Adjustment Problems, (15th percentile or below), 2000-2003

Behavior	2000-2001	2001-2002	2002-2003
Acting Out/Disruptive Only	3.9	5.0	4.7
Moody/Shy/Withdrawn Only	7.6	8.5	9.5
Problems Associated with Learning Only	4.4	4.4	4.2
Multiple Areas	8.6	10.6	13.3
One or more Areas	24.5	28.5	31.7

Source: Children's Institute

Life Experiences That Impact Social, Emotional and Behavioral Health, Children Entering Rochester City Schools

About the data: The source of this data is the PACE Survey, from the 2001-2002 school year, compiled by Children's Institute.

Parents Surveyed Reported the Following About their Children's Life Experiences:

- Only 55% have a father who spends time with them daily on a regular basis. This percentage increased from 50% in the 1998-99 school year.
- 22% have a father who almost never spends time with them regularly. This percentage decreased from 27% in the 1998-99 school year.
- 90% have a mother who regularly spends time with them daily.
- 21% have ever been away from their parents for more than one month.
- 12% have ever seen a family member with a drug or alcohol problem. The percentage of children who never saw a family member with a drug or alcohol problem increased from 81% in 1998 to 88% in 2001.
- 32% have experienced a parent's separation or divorce at least one time.

Elementary School Students with a Diagnosis of ADD/ADHD

About the data: The Rochester City School District keeps a Medi-Alert list of students who take medication in school and/or have a special health care plan for addressing a certain disease or condition during the school day. Students with a diagnosis of ADD/ADHD are included in this list only if they meet either of the two criteria listed above. These numbers therefore, are an underestimate of the prevalence of ADD/ADHD. Many physicians are now prescribing long-acting medications for this condition, so children do not have to take medication in school.

In the City of Rochester School District

- 1,085 elementary school students (about 7%) were listed on the Medi-Altert list with a diagnosis of ADD/ADHD during the 2002-2003 school year. According to the CDC, nearly 7% of children in the US have a diagnosis of ADD.[32]

[32] Attention Deficit Disorder and Learning Disability: United States, 1997-98. Series 10, No. 206. 18 pp. (PHS) 2002-1534. <http://www.cdc.gov/nchs/data/series/sr_10/sr10_206.pdf>

Students with a Significant Mental Health Diagnosis

About the data: The City of Rochester School District tracks the number of elementary school students with significant mental health diagnoses (including anorexia nervosa, bulimia, autism, Asperger disorder, depression, bi-polar disorder, and encopresis). Some students have both ADHD and/or mental health diagnosis, so the above numbers are a duplicated count. This data is from the 2002-2003 school year.

In the City of Rochester School District:

- 94 students (0.6%) have a diagnosis of one or more of the above disorders.

Current Funding and Policy Issues that Impact on Social and Emotional Well Being

Social and emotional well being in children is an issue for which no one professional discipline has complete responsibility. It is a part of the fields of early education and care, education, mental health, pediatrics and child development. The lay person might assume that it fits best in the field of mental health, but the mental health community has typically placed more emphasis on treatment of significant and severe mental health problems in adults than prevention in children.

Even though common sense and research indicates that social and emotional well-being is important, there are few national, state or local strategies to improve social and emotional well-being. It seems odd that communities have plans to increase immunization rates, increase school completion and increase cardiovascular health but almost no plans to improve social and emotional well being. No agency or organization is officially charged with this responsibility.

The 1999 Surgeon General's Report on Mental Health was remarkable because of its attention to many issues related to mental health in children including a focus on the fact that prevention can be effective. The report suggested that communities employ interventions with 'evidence of effectiveness' in reducing the incidence of mental health problems.

The Community Preventive Services Task Force[33], co-sponsored by both government and non-government organizations has begun to catalog the evidence of what interventions can be effective at the community level for a variety of outcomes. Recently, the task force has identified several interventions that relate to social and emotional well being.

For example, in 2002, the task force reported that there is scientific evidence to support that three community-level interventions can improve the social environment for children. These interventions are early care and education programs, tenant-based rental assistance programs and culturally competent health care. Earlier this year, the task force released a report that early childhood home visitation programs and firearms laws can be effective at reducing community violence.

Utilizing this evidence base, there is an opportunity for communities to improve social and emotional well being for children in a systematic way. Perhaps it is the responsibility of public health to incorporate improvement in social and emotional well being into community health improvement strategies such as **HEALTH *ACTION***.

[33] www.thecommunityguide.org

Current Community Activities and Programs Related to Social and Emotional Well Being

The Children's Institute Inc.

The mission of the Children's Institute is "to strengthen children's social and emotional competence and to prevent adjustment difficulties." Children's Institute has developed, researched and evaluated, and disseminated a number of evidence-based programs and assessment systems for children that are described briefly below.[34]

The Primary Mental Health Project (PMHP)

PMHP which started in Rochester 46 years ago, is now in 20 Monroe County, 250 NY State, and in over 2000 schools nationally. This evidenced based program is recognized by the New York State Education Department, the National Mental Health Association, the US Surgeon General Report on Mental Health and the US Department of Education as an exemplary prevention program. Multiple studies affirm that PMHP reduces negative adjustment behaviors and improves children's social and emotional well being. This school based prevention program works with children pre-kindergarten through 3rd grades by screening for social/emotional strengths and needs, and by providing trained child associates as direct service providers who meet with children individually or in small groups for 30 to 40 minutes a week for 20 weeks. Mental health professionals supervise and train child associates and consult with teachers and parents.

The Children of Divorce Intervention Program (CODIP)

CODIP is an evidence-based preventive intervention specifically designed to reduce the stress of a marriage breakup and enhance children's capacity to cope with family changes. Six different controlled studies document the effectiveness of the program with children of different ages and socio-demographic backgrounds. CODIP has been cited by New York State as an exemplary prevention program, and received the Lela Rowland Award for outstanding prevention programs from the National Mental Health Association.

[34] For more information, call (585) 295-1000 or log on to their web site http://www.childrensinstitute.net.

ACT-For the Children (Assisting Children through Transition)

ACT-For the Children is a parent education program designed to reduce the stress of a divorce on families. The primary goal of the program is to provide information and skills to parents that reduce the impact of a break-up, protect children from the toxic effects of on-going conflict and foster their resilience and healthy adjustment. Recent evaluations confirm attainment of these goals. ACT-For the Children is a collaborative effort of Children's Institute and the Seventh Judicial District.

Rochester Early Childhood Assessment Partnership (RECAP)

In 1992, RECAP, a collaboration of Children's Institute, early education and care providers, the Rochester City School District, and the foundation community, started to gather and analyze data on early childhood programs, which includes, but is not limited to, information on children's social and emotional well being. Results replicated over the past four years establish that children in high quality programs gain significantly in their social and emotional health.

Parent's Appraisal of Children's Experiences (PACE)

Starting in 1998 the Monroe County Department of Public Health, Children's Institute and the Rochester City School District worked together to develop what is now know as the Parent Appraisal of Children's Experiences (PACE). This instrument is part of the kindergarten registration packet in the city school district and routinely collects information on children's demographic background and life experiences, childcare experiences, general health, motor and sensory functioning, speech and language development, school skills, and social, emotional and behavioral functioning. Each year this data is compiled into an annual report to the community.

Rochester Safe Start

In 1998, the Monroe County Department of Public Health was awarded a five-year grant called Rochester Safe Start from the Federal Department of Justice. Under a contract with the health department, Children's Institute has developed innovative community-based approaches to the problem of children's exposure to violence. It is well documented that exposure to violence in childhood is associated with lessened social and emotional well being.[35]

Mt. Hope Family Center

Mt. Hope Family Center is part of the Clinical and Social Psychology Department of the University of Rochester. This cutting-edge service and research center provided services to hundreds of children with histories of abuse and neglect for over two decades. All services are based on research and are evaluated to ascertain their effectiveness. Some of the current evidence-based programs provided at Mt. Hope Family Center that enhances children's social and emotional well being are described.

Parent-child Attachment. This intervention directed to the parent-child relationship has been shown to be effective in improving mother-child relationships and in improving child cognitive development. This treatment approach has demonstrated efficacy for children of depressed mothers as well as for maltreated children.

[35] For more information, see http://www.nccev.org/programs/safe-start/rochester.html.

Parenting Skills Training. Mt. Hope Family Center's parenting groups utilize the Incredible Years curriculum, which is empirically supported and was selected by a Monroe County collaborative as one of the best available curricula for improving parenting skills for parents of young children.

After School Program. Mt. Hope Family Center's after school program utilizes the PATHS curriculum, an empirically-supported approach to developing appropriate expression of feelings, behavioral self-control, and improved social skills for school-aged children.

Interpersonal Psychotherapy for Depression. This program for depressed parents utilizes a documented effective, time-limited treatment to improve depression and enhance functioning.

Child Therapy. Through either individual or group formats, the Mt. Hope Family Center Child Therapy program for children who have experienced trauma utilizes cognitive-behaviorally focused treatment, drawn from treatment manuals that have been shown to be effective in research literature.

Family Resource Centers of Rochester (FRCR)

Family Resource Centers of Rochester (FRCR) is an independent not-for-profit organization that uses evidence-based educational programs to promote social and emotional well being in children.[36] Two programs offered by FRCR include: Parents as Teachers (PAT)[37] and The Incredible Years[38], which are nationally evaluated, research-based programs with validated components addressing social and emotional well-being for parents and children. These home and center-based programs teach parents the skills they need to support their children's social, emotional, and cognitive growth and well-being. FRCR early childhood education programs are scrutinized and improved through in-depth local evaluations[39] and through accreditation from the National Association for the Education of Young Children[40]

Parents as Teachers promotes social and emotional well-being of children through a research-based, developmentally appropriate curriculum. Home visits, parent groups, developmental screenings, and information and referral are the components of the program. "Based on research in child development and early education, the National Education Goals Panel identified five areas that play key roles in children's success in school. Dimensions of school readiness, the Panel determined, include physical well being and motor development, social and emotional development, approaches to learning, language development, and cognition and general knowledge. Parents as Teachers curriculum and training are designed to support the development of the whole child and include visit plans and content that address each of these research-based readiness dimensions."

Incredible Years – (see Parents Skills Training, Mt Hope Family Center shown above)

[36] For more information see www.frca.org
[37] For more information see www.patnca.org
[38] For more information see www.incredibleyears.org
[39] see www.children'sinstitute.net
[40] see www.naeyc.org

The Rochester Early Enhancement Project (REEP)

The Rochester Early Enhancement Project (REEP) is a collaboration of 13 agencies and 2 major funders to provide comprehensive intensive services to families with children from the prenatal stage to age 6 in the northeast, northwest and southwest quadrants of Rochester. REEP offers an array of family focused services. These include home and center-based pregnancy and parenting support and education and early childhood education for infants, toddlers and preschool aged children. REEP member agencies include: BabyLove, Charles Settlement House, Children's Institute, Daisy Marquis Jones Foundation, Healthy Moms, Community Health Worker Program, Monroe County Department of Public Health, Family Resource Centers of Rochester, Monroe County Department of Human and Health Services, Rochester Preschool Parent Program, United Way and the YMCA.

Reduce Child Abuse, Neglect and Violence Against Children

The Importance of Reducing Child Abuse/Neglect and Violence Against Children

Child abuse is the physical, sexual, or emotional abuse of a child by their parent or guardian. Such acts include fractures, head trauma, burns, lacerations, bruises, and excessive corporal punishment. Child neglect is the parent or guardian's failure to provide adequate food, clothing, shelter, supervision, education, or medical care resulting in the child's imminent risk of physical harm. Child abuse and neglect results in fatalities, short and long term medical problems, and life-long physical and emotional disabilities for its young victims. In addition, victims of maltreatment are more likely to suffer adverse life outcomes resulting from their increased risk for substance abuse, mental health disorders, suicide, school failure, teen pregnancy, and criminal behavior.

Measures of Child Abuse, Neglect and Violence Against Children

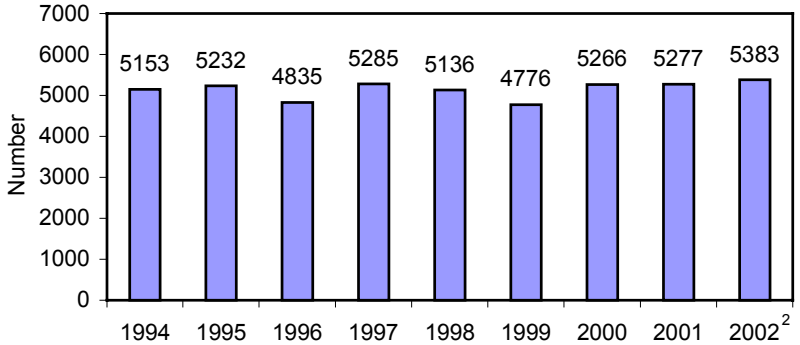
Reported Cases of Child Abuse and Neglect

About the Data: Incidents of child abuse and neglect are reported to Child Protective Services in Monroe County. Each report may involve more than one child, and a child may be included in more than one report, if separate incidents occurred. Care should be taken when interpreting these numbers. The data do not represent the actual prevalence of child abuse, since not all cases are reported and not all reports are indicated to be abuse or neglect. In addition, the number of reports may rise with increased publicity or media coverage about child abuse issues. These reports include children under age 18. The source is the New York State Office of Children and Family Services.

In Monroe County:

There were 5,383 reported cases of child abuse and neglect in 2002. The chart to the right illustrates that the number of reports fluctuated between 1994 and 1999 and then increased starting in 2000. It is unclear what caused the increase. It could be due to an actual increase in child maltreatment and/or an increase in reporting. The rate of child abuse and neglect reports per 1000 population in Monroe County (28.6/1000) is the same as the rate in comparison counties[41]

Reports of Child Abuse and Neglect[1], Monroe County, 1994-2001



Source: MAPPS, New York State Office of Children and Family Services,
[1]These numbers are different from the numbers reported by the Monroe County DHHS because they only include cases that originated in Monroe County.
[2] Preliminary

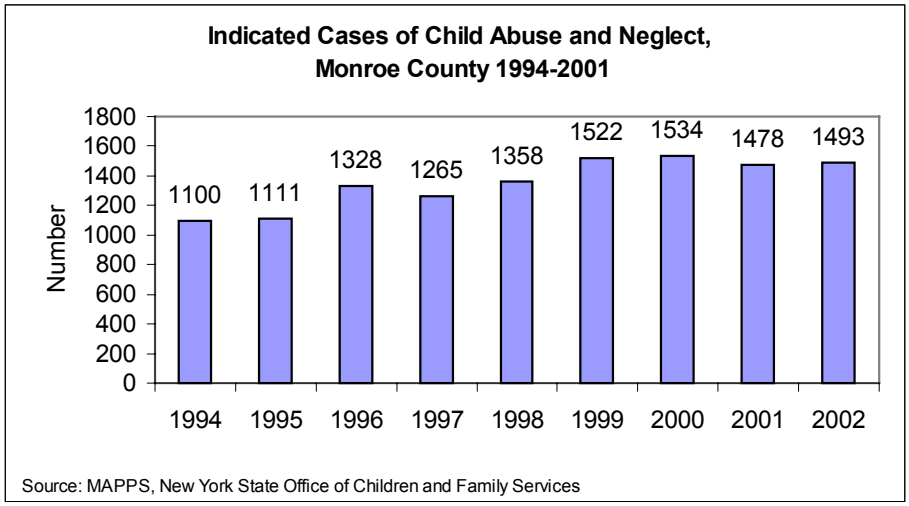
[41] Erie, Onondaga, Suffolk, Nassau, Westchester, Monroe

Indicated Cases of Child Abuse and Neglect

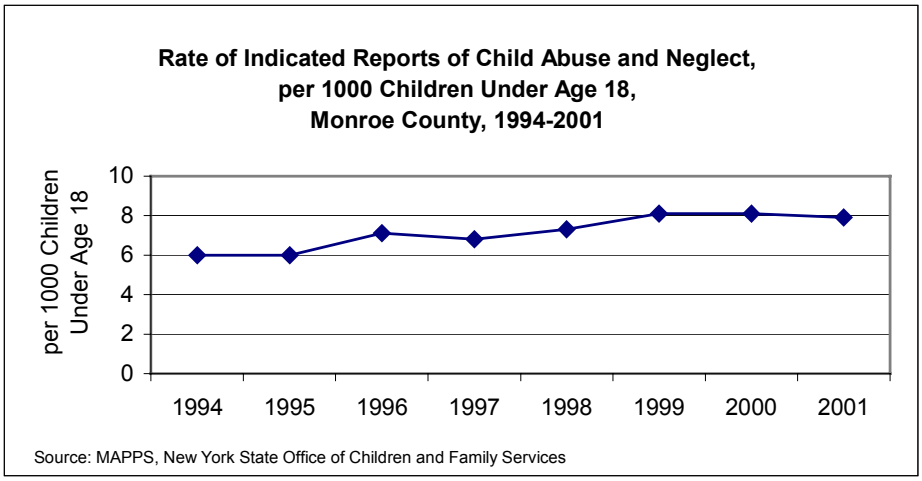
About the Data: Indicated reports of abuse and neglect are those reports in which a Child Protective Services investigation reveals credible evidence that abuse or maltreatment occurred. More than one child can be included in a report. These data include cases in which reports were taken in the given year, and were indicated within that same year or within the first 3 months of the next year. Care should be taken when interpreting these numbers. The data do not represent the actual prevalence of child abuse, since not all cases of child abuse and neglect are reported and then investigated. These data include children under age 18. The source is New York State Office of Children and Family Services.

In Monroe County:

In 2002, there were 1,493 indicated cases of child abuse and neglect among children under age 18. The number of cases has increased since 1994.



The rate of indicated cases per 1000 children in Monroe County, increased between 1994 and 2001.



In 2001, the rate of children in indicated cases in Monroe County (7.9/1000) was about the same as rates in comparison counties[42].

[42] Erie, Onondaga, Suffolk, Nassau, Westchester, Monroe

Allegations of Child Abuse and Neglect

About the Data: Within each report of child maltreatment, there is at least one allegation. An allegation is an accusation of a specific type of maltreatment that may or may not be indicated. According to data obtained from the Office of Children and Family Services for the first five months of 2002, most allegations of child maltreatment are allegations of neglect (85%) the remaining are allegations of abuse (15%). The most common allegations of neglect are inadequate guardianship, parent's drug/alcohol misuse, and lack of supervision. The most common allegations of abuse are lacerations, bruises, and/or welts, excessive corporal punishment and sexual abuse.

Allegations of Child Abuse and Neglect,
Monroe County,
First Five Months of 2002,

Allegations	% of all Allegations
Inadequate guardianship	47
Parent's drug/alcohol misuse	13
Lack of supervision	11
Inadequate food, clothing, shelter	8
Other Neglect	6
Total Neglect Allegations	85
Lacerations, bruises, welts	7
Excessive corporal punishment	4
Sexual abuse	3
Other Abuse	2
Total Abuse Allegations	15

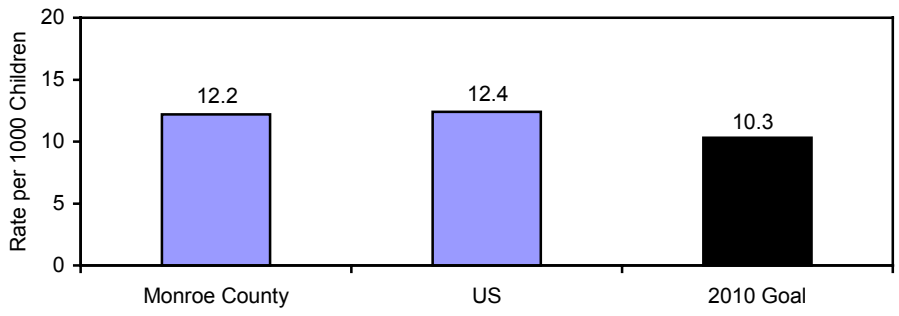
Source: NYS Office of Children and Family Services, State Central Register, Summary Characteristics Report as of May 31, 2002

The number of children involved in situations where there were substantiated (proven) allegations of child abuse and neglect is obtained from the data warehouse of the New York State Office of Children and Family Services. This data is different from data on the previous pages in that it is a count of children in substantiated allegations. Care should be taken when interpreting these numbers. The data do not represent the actual prevalence of child abuse, since not all cases of child abuse and neglect are reported and then investigated. There may be more than one child per allegation. This data is used in addition to the data on the previous pages because it is available by age and geographic area.

In Monroe County:

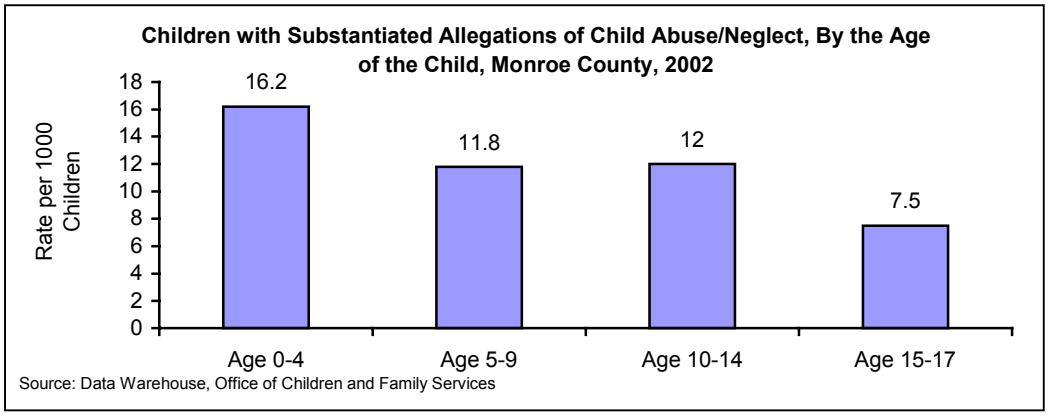
In 2002, there were 2,306 children under age 18 with at least one substantiated allegation of child abuse and/or neglect. The child maltreatment victimization rate in Monroe County is similar to the rate in the US in 2001, but has not met the 2010 Goal. for the Nation.

Children Under age 18 In Substantiated Allegations of Child Maltreatment, Monroe County (2002), US (2001) and the Year 2010 Goal

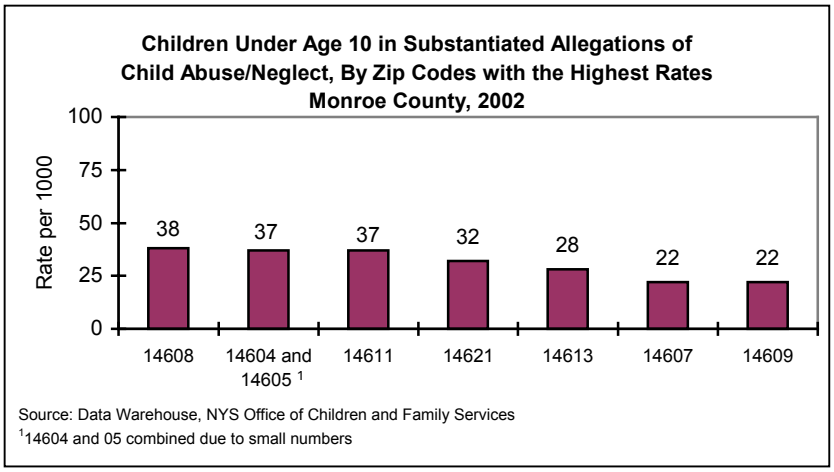


Source: Monroe County - Data Warehouse NYS Office of Children and Family Services, US data, Child Maltreatment, 2001, Administration for Children and Families, www.acf.hhs.gov/programs/cb

Of the children involved substantiated allegations, 1,409 were under age 10. As shown in the chart below, the highest rate of substantiated allegations are among children under age 5.



The highest rates substantiated cases of child maltreatment among children under age 10 occur in several of the high-risk zip codes within the City of Rochester, as shown in the chart to the right.



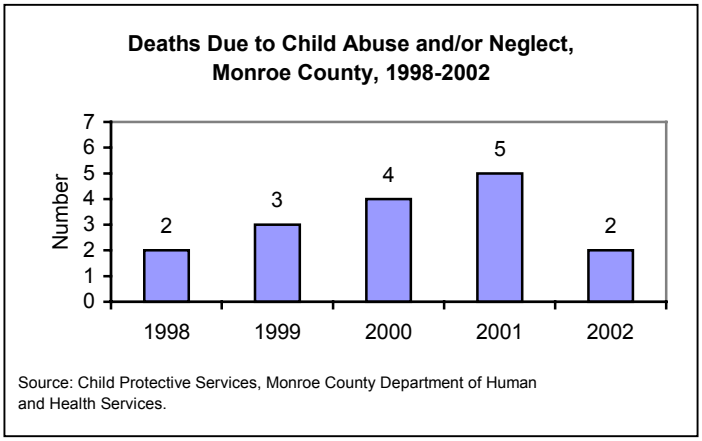
Deaths Due to Child Abuse and Neglect

About the data: This is the number of children under age 18 in Monroe County who died due to child abuse and/or neglect. The Child Protective Services Unit (CPS) investigated each of these deaths and determined there was credible evidence that abuse or maltreatment caused the death. The source is Child Protective Services of the Monroe County Department of Human and Health Services.

In Monroe County:

There were between 2-5 deaths due to child abuse and/or neglect each year from 1998-2002. The numbers of deaths that occurred each year are shown in the graphic to the right.

The child maltreatment fatality rate in Monroe County (1.7/100,000)[43] is similar to the rate in the US and is above the 2010 Goal (1.4%).



[43] 1998-2002

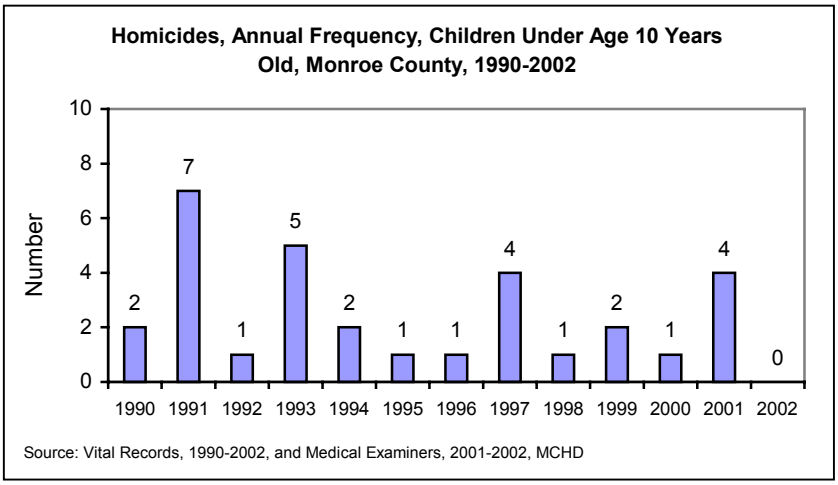
Homicides, Children Under age 10

About the Data: This is the number of children under age 10 who died of homicide. These figures may include children who died of child abuse. The source is the Department of Vital Records of the New York State Health Department for 1990-2000, and the Monroe County Office of the Medical Examiner for 2001 and 2002.

In Monroe County:

There were between 0-7 deaths of children under age 10 due to homicide each year between 1990 and 2002.

80% of the children that died, lived in the City of Rochester, and nearly two-thirds of them were African American.



Hospitalizations Due to Assault

About the Data: This data includes the number of hospitalizations due to assault among Monroe County children under age 11. The source is SPARCS, NYSDOH.

In Monroe County:

Between 1992 and 2002, there were on average about 12 hospitalizations due to assault each year among children under age 11. 40% were African American, 35% were White and 15% were Hispanic. Most (81%) resided in the high-risk zip codes[44] of the City of Rochester.

Children Who Witness Violence

About the data: The source of this data is the PACE Survey from the 2002-2003 school year, compiled by Children's Institute.

Parents Surveyed Reported the Following About their Children's Exposure to Violence:

- 21% had ever witnessed violence in the neighborhood. Nine percent had witnessed it two or more times.
- 14% had ever witnessed violence in the home. Five percent had witnessed it two or more times.

[44] 14604, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 19, 20, 21

Emerging Issues Related to Reducing Violence- and Child Maltreatment

While rates of violent crimes have been falling around the country, the public perceives that violence continues at an unacceptable level. This has led politicians, social scientists and criminologists to seek new approaches to prevent violence.

Under the leadership of former Attorney General Janet Reno, the federal department of justice has suggested that communities need comprehensive approaches to violence prevention and intervention. Popular approaches have involved community-policing efforts and enhanced drug prevention efforts.

Many child psychologists believe that exposure to violence in early childhood places a child at risk to become either a victim or perpetrator of violence in the future. This theory suggests that breaking the cycle of violence in a local community can occur through the reduction of exposures to violence or the proper care for children exposed to violence through support and counseling.

This theory is a radical departure from the traditional thinking about violence prevention. Traditionally, violence prevention interventions have targeted adults in the criminal justice system and high-risk adolescents. Research now being conducted suggests approaches to prevent the cycle of violence in early childhood. Research done at the Mt. Hope Family Center has demonstrated that when children are exposed to violence, human brain development is altered. Studies have shown that children exposed to violence follow unusual developmental paths that are different from unexposed children. Typically, these children are less resilient in accomplishing developmental tasks often leading to learning, social and emotional problems.[45]

Recently, the Task Force on Community Preventive Services made the recommendation to implement or continue early childhood home visitation programs because they are effective in reducing child abuse and neglect among high-risk families. A systemic review of studies showed that home visitation resulted in a 40% reduction in maltreatment episodes. [46] Home visitation programs are defined as programs in which trained personell visit parents and children in their home and provide education to parents on various topics including infant care, parenting, child abuse and neglect prevention, child development, and life skills for the parents.

Community Programs to Reduce Child Abuse, Neglect and Violence Against Children

Do Right By Kids (DRBK)

DRBK is a public health communications program sponsored by Monroe County government designed to reduce the local incidence of child abuse and improve the community response to reported cases. The program has three components: a mass media campaign designed to raise awareness about the problem of shaken baby syndrome, a professional education campaign for mandated reporters to improve identification and management of suspected cases and a campaign to promote positive parenting.

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[45] For more information see www.mthopefamilycenter.org

[46] http://www.thecommunityguide.org/violence/viol-int-homevisit.pdf

The mass media campaign related to shaken baby syndrome ran in 2002 and has been completed.[47]. Funding for the positive parent campaign has not yet been identified. The professional education campaign related to mandated reporter training began in fall 2003 and will continue through 2004.

The Do Right By Kids web site contains information on how to:

- Recognize child abuse and neglect
- Call in reports of child abuse and neglect
- Help prevent child abuse and neglect
- Find out about resources to help families[48]

Rochester Safe Start

Safe Start is the name of a local initiative to reduce the impact of exposure to violence on young children. The Monroe County Department of Public Health received a grant from the U.S. Department of Justice for this five-year initiative. The Public Health Department contracted with the Children's Institute to administer this program.

Safe Start is based on the premise that exposure to violence in early childhood places a child at risk to become either a victim or perpetrator of violence in the future. The project believes that breaking the cycle of violence in a local community can occur through the reduction of exposures to violence or the proper care for children exposed to violence through support and counseling.

Safe Start projects include a small media campaign called the Shadow of Violence, a training program for human services worker, a mentoring program for pre-school teachers and a pilot intervention with the Rochester Police Department located in the Maple Section.[49]

Preventive Services, Monroe County Department of Health and Human Services

Monroe County purchases preventive services from a number of community agencies for families in which children are in imminent risk of foster care placement. These services are aimed at preserving family function so that foster care placement can be avoided.

Additional Programs Providing Education and Support for Parents

The Rochester Parent Network is a community-wide communication system to provide education and support to parents and caregivers of very young children, with the ultimate goal to help every child reach their full physical, emotional and cognitive potential. The network allows parents and caregivers to communicate with each other, as well as with professionals, using the internet, telephones and television.[50]

The Monroe County Community Health Worker Program and Baby Love Program are home visitation programs that promote parenting skills and the health and development of infants.

The Family Resource Centers and Head Start Programs offer parent education programs focusing on child development and reasonable expectations for preschool aged children.

[47] For more information, contact dross@monroecounty.gov
[48] www. www.dorightbykids.org
[49] For more information, contact kreixach@childrensinstitute.net.
[50] for more information call 292-BABY (2229) or www.rochesterparentnetwork.org

Index of Maternal/Child Health Indicators

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